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An Editorial

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*Jeans, P. C. and Marriott, W. M.: Infant Nutrition, 4th ed., C. V. Mosby Co., 1947.

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Volume XXXV JULY, 1948 No. 1

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This Journal is not responsible for the opinions and statements of its contributors.

Published monthly at Jacksonville, Florida. Price $5.00 a year; single numbers, 50 cents. Address Journal of the Florida Medical Association, P. O. Box 1018 (Fla. Theater Bldg.), Jacksonville 1, Fla. Telephone 5-0577. Accepted for mailing at special rate of postage provided for in Section 1103, Act of Congress of October 3, 1917; authorized October 16, 1918. Entered as second-class matter under Act of Congress of March 3, 1879, at the post office at Jacksonville, Florida, October 23, 1924.

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1 Stuart, H.C.: Effects of Protein Deficiency on the Pregnant Woman and Fetus and on the Infant and Child, New England J. Med. 236:507 (Apr. 3) 1947.

2 Zeigler, R.F., Jr.: Pre-eclamptic Toxemia of Pregnancy. North Carolina M. J. 8:655 (Oct.) 1947.

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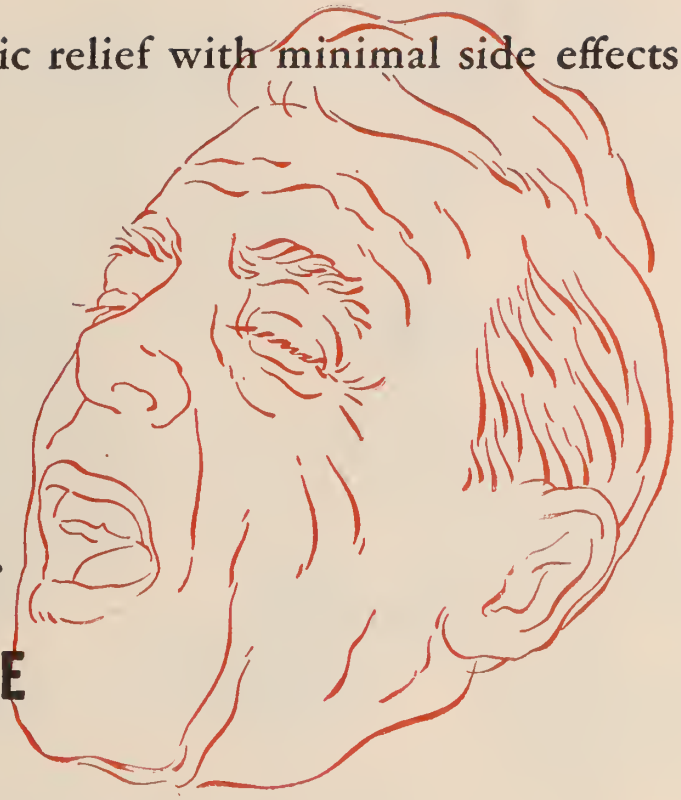
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1. Arbesman, C. E.: *N. Y. State Jl. of Med.*, 47: 1775, 1947.
2. Loveless, M. H.: *Am. Jl. of Med.*, 3: 296, 1947.
3. Bernstein, Rose and Feinberg: *Ill. Med. Jl.*, 92: 2, 1947.
4. Osborne, Jordon and Rausch: *Arch. of Derm. & Syph.*, 55: 318, 1947.

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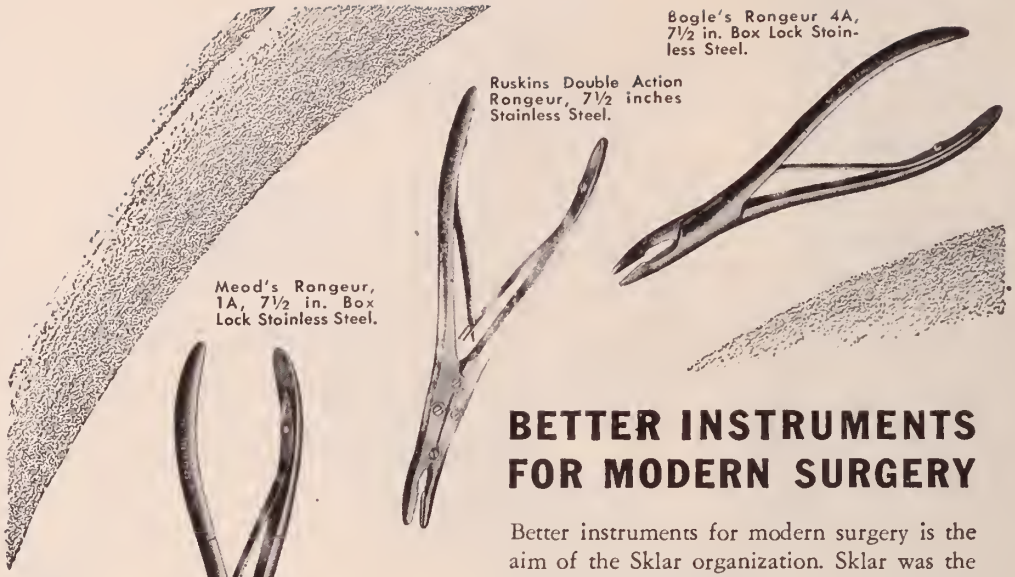
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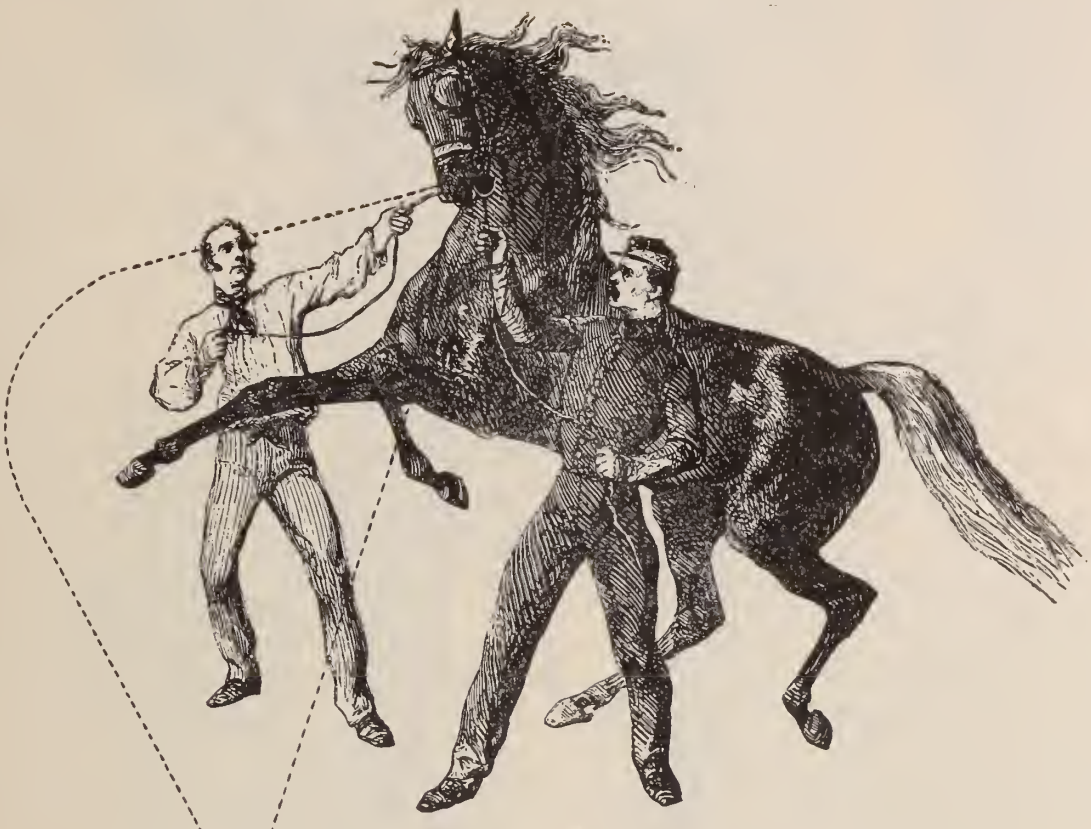
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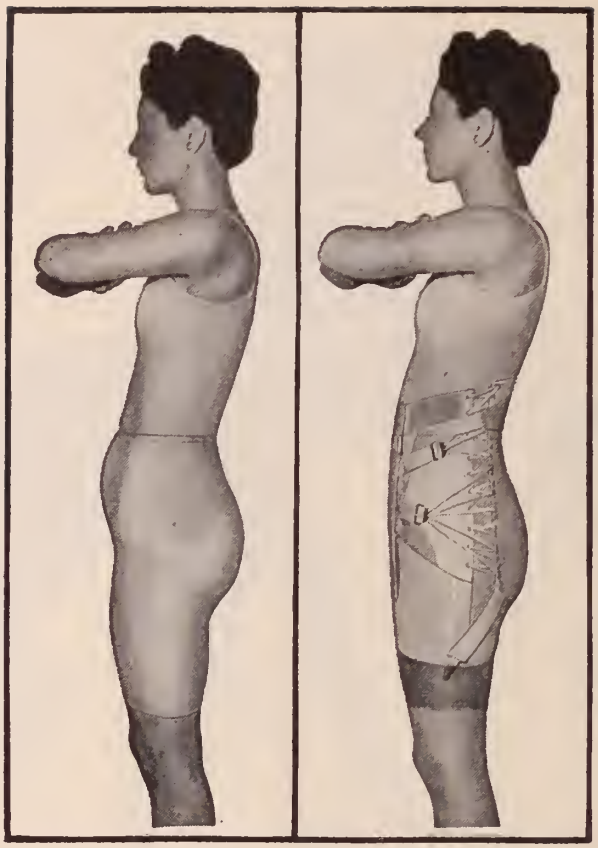
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THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION
PUBLISHED MONTHLY
Volume XXXV Jacksonville, Florida, July, 1948 No. 1

The Fenestration Operation for Otosclerosis Analysis of One Hundred Cases

J. Brown Farrior, M.D.
TAMPA

The deafness in otosclerosis is produced by a new growth of bone which fixes the foot plate of the stapes, closes the oval window and prevents the entrance of sound into the inner ear. Early in the course of this affliction, the inner ear retains normal or nearly normal function. If such an inner ear is opened, hearing is restored. This fact has been known for fifty years.[1] Only, however, with the advent and perfection of the one stage Lempert fenestra nov-ovalis technic[2] was the fenestration operation made practical and the hearing gain maintained in the overwhelming percentage of cases.

In the beginning, the fenestration operation was heralded, not with enthusiasm, but with scorn and ridicule. In the past eleven years, it has been subjected to the severest analytic scrutiny of the most conservative otologists. The fenestration operation is now an accepted surgical procedure and has been hailed as one of the greatest advances in all of modern surgery.

As members of the medical profession, you will be interested in the general technic of the fenestration operation, the reasons for its success, the type of patient in which the operation is indicated, and the results which may be expected.

TECHNIC

The fenestration operation is performed through an endaural incision which permits direct access to the mastoid. A partial mastoidectomy is done to expose the external surface of the horizontal semicircular canal. The bony wall of the posterior and superior portion of the external auditory canal is removed to permit the skin of the same area to be utilized as a flap which will later cover the fenestra. The incus and the head of the malleus are removed to gain access to the broader, domelike ampullated end of the horizontal canal (fig. 1) immediately superior to the oval window. The cutaneous lining of the superior and anterior portion of the auditory canal, continuous with the upper portion of the tympanic membrane, is then turned as a tympanomeatal flap (fig. 2). The flap is so manipulated that the thinnest possible skin of the anterosuperior wall covers the new fenestra. The flap is held in position by the gentle pressure of a rayon-lined synthetic sponge dressing.

In the performance of the fenestration operation, there are many critical factors upon which rest the success or failure of the operation. First in importance is the removal of all osteogenic elements. All osteogenic periosteal bone should be removed from the ampulla of the horizontal semicircular canal so that the fenestra is surrounded only by the relatively nonosteogenic enchondral bone. The fenestra must be made on the flattened dome of the ampulla, for, if the window is in the bottom of a trough, the margins will fill with scar tissue, an ideal medium for the ingrowth of osteoblasts. All osteogenic bone spicules and endosteum must be removed from the fenestra. The endosteal margins of the fenestra must not be traumatized or elevated; for, as Shambaugh[3a] noted, this change will also stimulate scar formation, the ideal bed for osteoblasts. The under surface of the flap must be thoroughly debrided and all microscopic bone spicules removed, for only the smallest bone spicule placed over the fenestra will serve as an osteogenic focus which will soon occlude the fenestra.

In the use of the surgical burr, both in the preparation of the cavity and the making of the fenestra, the cavity is continuously seeded with osteogenic bone dust. Shambaugh[3b,c,d] pointed out the value of continuous irrigation in the removal

Read before the Florida Medical Association, Seventy-Fourth Annual Meeting, St. Augustine, April 11-14, 1948.
From the Department of Otorhinolaryngology, Tulane University of Louisiana School of Medicine, and the Section on Otology, Ochsner Clinic, New Orleans, La.

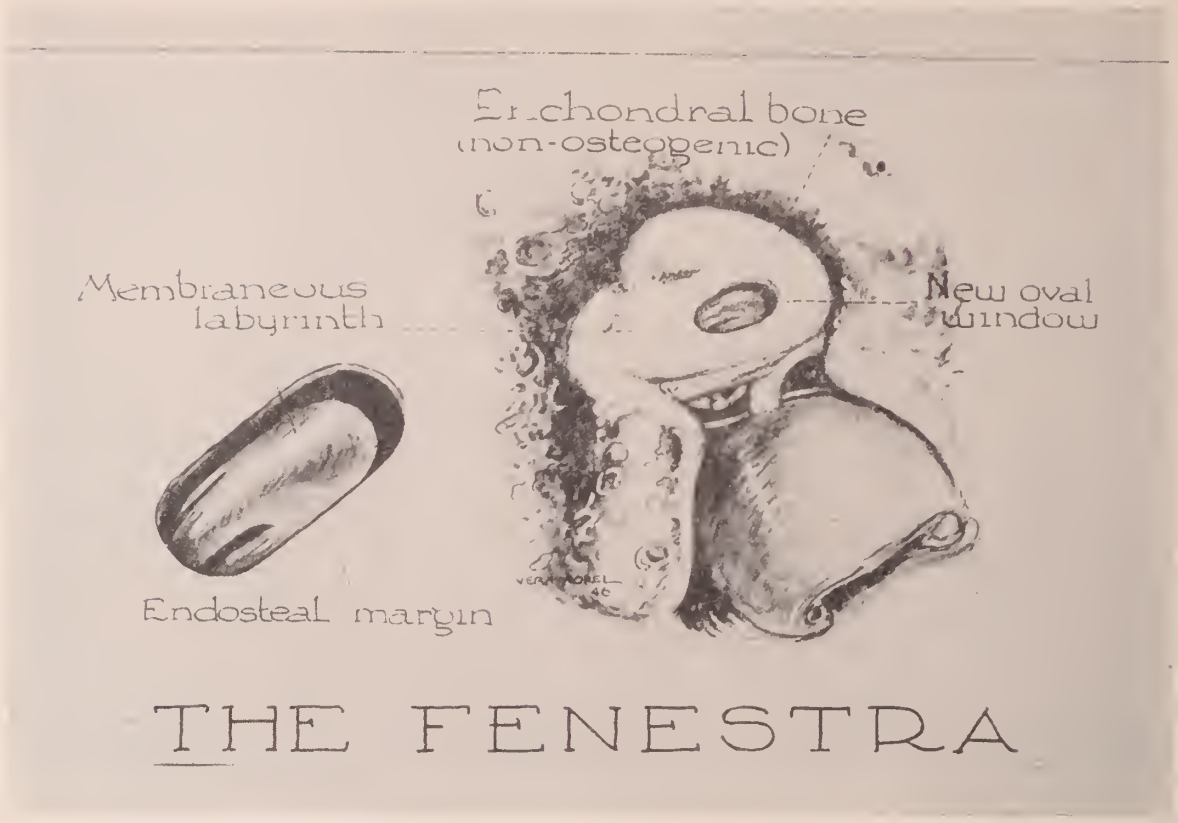


Fig. 1.—The Fenestra: Demonstrates the new oval window situated well forward in the broad ampullated end of the horizontal semicircular canal and surrounded by a wide area of relatively nonosteogenic enchondral bone. The inset demonstrates the complete removal of all osteogenic bone spicules and endosteum and the resultant smooth margins of the fenestra; the membranous labyrinth is visualized. All microscopic bone spicules have been removed from the under surface of the flap.

of this bone dust. In addition, it has recently been my practice never to expose the under surface of the flap to this osteogenic bone dust, but to keep the flap continuously protected with a layer of rayon, which will trap all osteogenic seeds of bone dust; only when the fenestra is completed is this protective rayon pledget removed, to permit the virginal under surface of the flap to be placed over the fenestra. Day[1] observed that minimal trauma to the flap will result in minimal postoperative labyrinthine reaction. Shambaugh[3d] concluded that the thinnest, most ideal covering for the fenestra is to be found in the skin of the anterosuperior portion of the external auditory canal. It is these minutiae of technic which make the fenestration operation surgically fascinating and result in the maintained success for the Lempert fenestra nov-ovalis operation.

The technic briefly described is the classical fenestration procedure, which has proved successful in hundreds and hundreds of cases in the hands of competent surgeons. The cartilage stopple,[2d] once heralded as the final solution to the problems of closure of the fistula and the prevention of postoperative labyrinthine reaction, has been discarded as a failure. There are other refinements in technic now under investigation; some of these will no doubt be definite contributions to fenestration surgery. None of them, however, have had the proved success of the classical technic described here.

THE SELECTION OF PATIENTS

The fenestration operation is indicated in moderate degrees of otosclerosis with good or fairly good inner ear function. It is not indicated in severe otosclerosis with poor inner ear function. The air conduction audiogram determines the degree of deafness; to date, the most practical method of evaluating inner ear function is by bone conduction, as determined both with the audiometer and with the tuning forks.

Arbitrarily, the deafness in otosclerosis may

be classified as early, moderate, moderately severe and severe. In early otosclerosis, the hearing for the speech frequencies of 512 (C2), 1024 (C3) and 2048 (C4) remains at or above the 30 decibel level; in cases of this type, the auditory handicap has not yet progressed to the level of deafness, and the patient does not need a fenestration operation. In moderate otosclerosis, the patient presents a flat or ascending air conduction audiogram, with the hearing for the speech frequencies below the 30 decibel level; the bone conduction is within the limits of normal with the audiometer and with the tuning forks. Such a patient is an ideal candidate for the fenestration operation (fig. 3). In moderately severe otosclerosis, in the air conduction audiogram the line slopes gently downward; in the bone conduction audiogram it is sloping, crossing not below the 30 decibel level at the frequency of 2048; bone conduction is normal with the 1024 tuning fork and shortened with the 2048 tuning fork. Patients with this type of impaired hearing are fair candidates for the fenestration operation. In severe otosclerosis, the line of the air conduction audiogram slopes sharply downward; audiometrically the bone conduction is below the 30 decibel level for one or more of the speech frequencies; with the 1024 fork the bone conduction is shortened, with the 2048 fork the bone conduction is markedly shortened or absent. Patients with deafness of this type are more wisely advised to utilize a hearing aid.

In all auditory testing, the greatest reliance is placed in the tuning forks.[5a,b] The audiogram may be erroneous, but calibrated tuning forks are not deceiving. I prefer the magnesium tuning fork, as advocated by Meltzer, for the prolonged duration of vibration reduces the margin of error. My own tuning forks are calibrated in the fixed conditions of my own soundproofed room. Under these fixed conditions, my 512 fork is normally heard one hundred twenty seconds by air conduction and sixty seconds by bone conduction (120 AC/60 BC), the 1024 fork is normally heard ninety seconds by air conduction and forty-five seconds by bone conduction (90 AC/45 BC), the

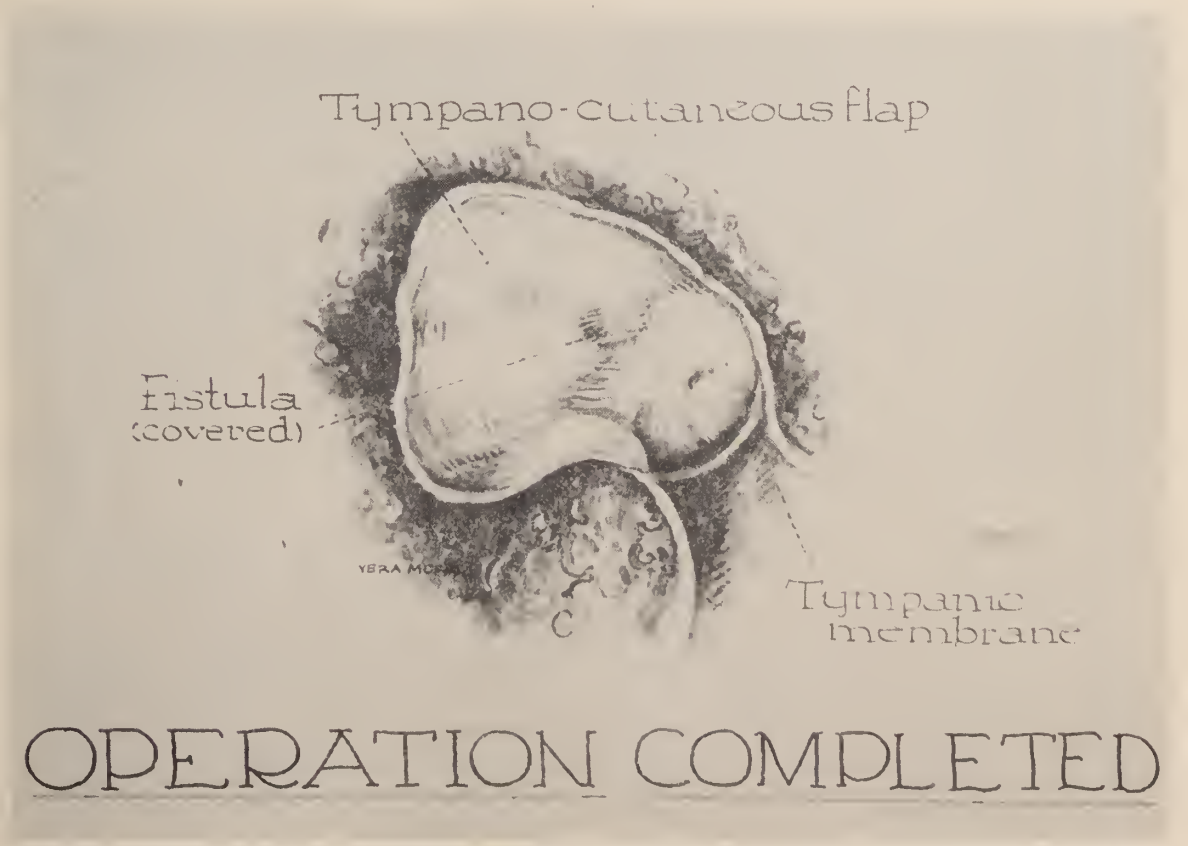


Fig. 2.—The Flap: The thin tympanocutaneous flap covers the fistula and is directly continuous with the upper portion of the vibrating tympanic membrane.

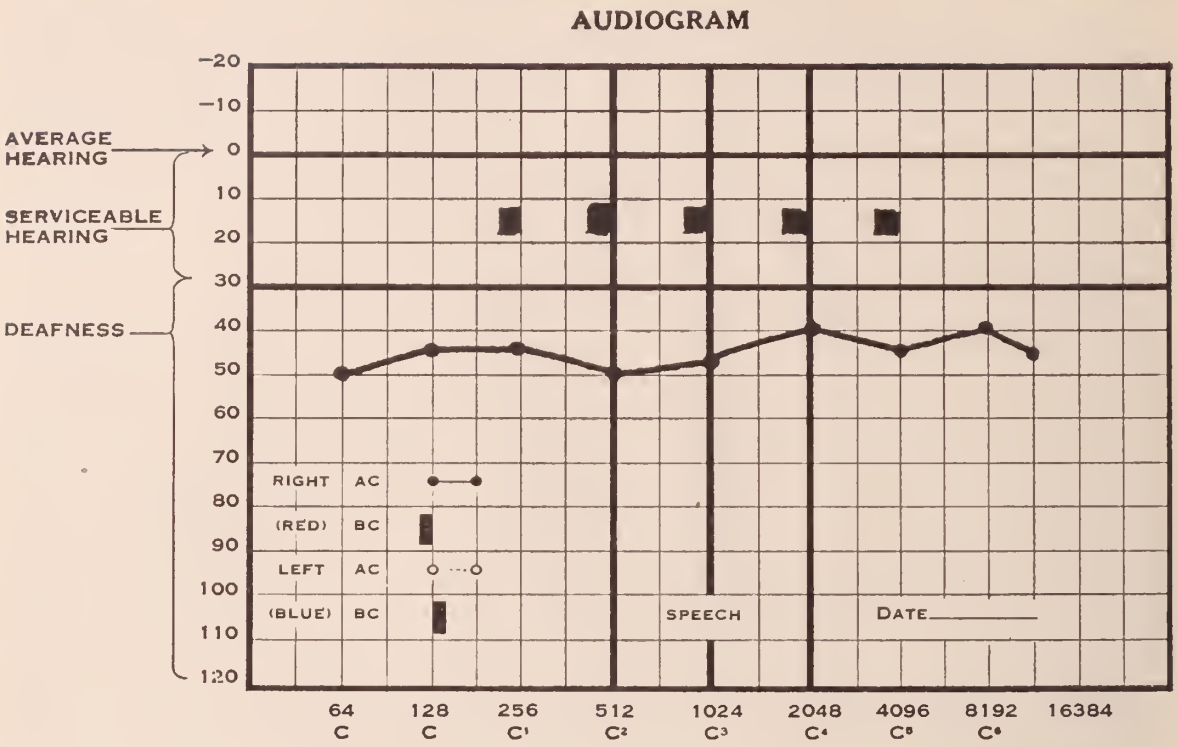


Fig. 3.—The ideal candidate for the fenestration operation presents a flat or ascending air conduction audiogram with normal bone conduction.

2048 fork is normally heard forty seconds by air conduction and twenty seconds by bone conduction (40 AC/20 BC). In otosclerosis, the air conduction is shortened and the bone conduction is relatively prolonged. In evaluating the candidate for the fenestration operation, the most valuable single test is the 1024 tuning fork. If the bone conduction is normal or prolonged with the 1024 tuning fork, the patient is probably a suitable candidate for the fenestration operation; if the bone conduction is appreciably shortened with the 1024 tuning fork, the patient is probably not a suitable candidate for this operation. The complete preoperative study of a candidate for the fenestration operation requires approximately one hour, while in your office practice the single test with the 1024 fork may be accomplished within a few minutes.

As will be described in the results, the patient's response to the audiometric and tuning fork test is always correlated with the patient's ability to interpret low conversational voice and the whisper. When, in a quiet room, with the eyes closed, the patient is unable to understand low conversational voice at a distance of 3 feet, the auditory handicap has progressed to the level of deafness, and the fenestration operation should be considered.

RESULTS

HEARING IMPROVEMENT.—The purpose of the fenestration operation is to restore useful hearing. Technical perfection being constant, the possibility of obtaining this goal is directly proportional to the degree of retained inner ear function (table 1). In this series, 85 patients with moderate and moderately severe otosclerosis had good bone conduction; 81, or 95.3 per cent, obtained useful hearing. There were 15 patients with moderately severe otosclerosis and with fair bone conduction; 10, or 66.6 per cent of these, received useful hearing. In the overall series of 100 good and fair candidates operated on by me at the

TABLE 1.—IMMEDIATE RESULTS

Bone Conduction	Hearing Restored	Failures	Per Cent Rehabilitated
85 good	81	4	95.3
15 fair	10	5	66.6

This table demonstrates that useful hearing may usually be expected from a fenestration operation when the patient has good bone conduction.

Ochsner Clinic in New Orleans, 91 per cent received useful hearing.

The hearing restored by the fenestration operation is serviceable hearing, permitting the formerly deaf patient to conduct normal conversation, attend motion pictures and church without difficulty and without the use of a hearing aid; it is not perfect hearing.

In this series, there were 85 patients receiving good results with the hearing restored to at or above the 30 decibel level. Audiometrically (table 2), the hearing of these patients for the speech frequencies was improved from an average preoperative level of 50.3 decibels to an average postoperative level of 19.4 decibels, an average gain of 30.9 decibels. In practical language, this improved their ability to understand low conversational voice from an average preoperative maximum distance of 4.7 inches to an average postoperative distance of 200.4 inches, or 16.7 feet.

TABLE 2.—HEARING IMPROVEMENT

Number Cases	Average Preoperative Hearing	Average Postoperative Hearing	Average Hearing Improvement
85 good results	50.3 db	19.4 db	30.9 db
6 fair results	50.6 db	33.8 db	16.8 db

The hearing improvement is shown in decibels. The hearing for low conversational voice was improved from a preoperative average maximum distance of 4.7 inches to a postoperative average distance of 200.4 inches for the 85 patients obtaining good results and from a preoperative average of 2.6 inches to a postoperative average of 72 inches for the 6 obtaining fair results.

In this series, there were in 6 cases fair results, which permitted the patients to discard the use of the hearing aid. Audiometrically (table 2), the hearing of these patients for the speech frequencies was improved from an average preoperative level of 50.6 decibels to an average postoperative level of 33.8 decibels, an average gain of 16.8 decibels. In practical language, this improved their ability to understand low conversational voice from an average preoperative maximum distance of 2.6 inches to an average postoperative distance of 72 inches, or 6 feet. Supplementing this hearing with what they can see, these patients are able to conduct their normal affairs. Strangely enough, they are among the most grateful patients in the series.

Closure of the Fistula.—By refinements in technic,[2b,3a,d] the incidence of closure of the fistula has been reduced to a minimum (table 3).

TABLE 3.—CLOSURE OF FISTULA

Postoperative Period	Number of Cases	Closures	Hearing Maintained
12 to 24 mo.	37	2	95.6%
6 to 12 mo.	42	3	92.9%

This table demonstrates that when the technic is minutely accurate the restored hearing is usually maintained.

If the fistula is going to close, it will usually close in the first three to six months postoperatively. Of 37 patients who regained useful hearing after having this operation from twelve to twenty-four months ago, 35, or 95.6 per cent, have maintained the hearing gain. Of 42 patients who were operated on from six to twelve months ago, 39, or 92.9 per cent, have maintained the hearing gain.

Do not be deceived by these apparent good results. This series is as yet immature. In the final summation of results at the end of the two year postoperative period, there will undoubtedly be more closures. As a beginner in the field of fenestration surgery, I have, however, been encouraged by the high incidence of gratifying results. With further refinements in the fenestration operation and with experience and improvement in my own technic, it is reasonable to assume that this incidence of bony closure will be further lowered. Certainly, closure of the fistula, the original pitfall of the fenestration operation, has been reduced to a point where the otologist can state, "The hearing restored by a properly performed fenestration operation is usually maintained."

Tinnitus.—In 30 of 36 patients who complained of tinnitus, this condition was relieved or greatly improved. In 3 it remained unaltered, and in 3 it became worse.

Complications and Sequelae.—The fenestration operation is relatively free from serious risk. In this series, no suppurative labyrinthitis, no permanent facial paresis, no permanent facial paralysis, no intracranial complication, no anesthetic complications and no deaths have occurred. There are some nuisance factors which are incidental to the operation. The greatest single nuisance factor is the annoying otorrhea. In 1 case, the otorrhea persisted and required excision of the granulation tissue and lining of the cavity with a split thickness skin graft. In 2 additional

cases, the same plastic procedure on the cavity may be required. In 1 case in which the patient was dismissed too early, there developed stenosis of the external auditory canal, which required excision of the cicatrix and lining of the cavity with a split thickness skin graft. My present utilization of Hoople's modification of the Shambaugh incision greatly facilitates the postoperative healing of the fenestration cavities and prevents stenosis of the canal.

Facial paralysis has been greatly overstressed as a possible sequela of the fenestration operation, for, during the course of this operation, the intratympanic course of the facial nerve is visualized and may be avoided. Because of the proximity of the fenestra to the nerve, a transient postoperative paralysis may occasionally develop, as occurred from the eighth to the twenty-first postoperative day in 1 case of this series. Although such a paralysis may be temporarily humiliating, it is of no permanent consequence because of its transient nature.

The gravest sequela of the fenestration operation is the psychologic depression in those cases in which the operation has been disappointing. There is no more grateful patient than one who has experienced the restoration of hearing, but no amount of preoperative or postoperative explanation can overcome the depression which follows a failure. It is for this reason that I will advise the fenestration operation only upon those patients with good bone conduction and in whom there is every reason to expect a gratifying result.

SUMMARY

The technic of the fenestration operation is briefly described. The protection of the flap with a rayon strip is advocated during any bone work to prevent the seeding of the flap with osteogenic bone dust.

The selection of patients for the fenestration operation is outlined.

Of 85 patients with good bone conduction, 95.3 per cent received useful hearing. Of 15 patients with fair bone conduction, 66.6 per cent received useful hearing. In the hearing of these patients experiencing good results there was an average gain of 30.9 decibels.

In the cases in which twelve to twenty-four months have elapsed postoperatively, 95.6 per cent of the patients who regained useful hearing have maintained the hearing gain. In the cases in which there has been a lapse of from six to twelve months since the operation, 92.9 per cent of those who regained useful hearing have maintained the hearing gain.

In the 100 cases of this series in which the fenestration operation was performed, there were no serious complications and no deaths.

CONCLUSIONS

1. In properly selected patients, a properly performed fenestration operation is relatively free from serious risk.

2. The operation is usually successful, and the hearing is usually maintained.

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DISCUSSION

DR. THOMAS M. EDWARDS, Tampa: I should like to congratulate Dr. Farrior on the clarity and simplicity of his paper. Both are unusual in this type of paper.

As Dr. Farrior has mentioned, the fenestration operation is becoming an acceptable surgical procedure after a rather stormy period of trial. I believe that the future success is dependent on two factors, the first of which is the proper selection of patients. The patients must be meticulously examined to determine if there is an adequate cochlear reserve. The skill and training of the surgeon is the second factor. One should not perform the operation unless he has had adequate training and practice before attempting the procedure. It is not an operation to be undertaken casually.

I should like to bring to your attention an article in the January Laryngoscope by Dr. W. R. Thurlow and others of St. Louis. As Dr. Farrior has mentioned, there is a group of patients in whom the operation cannot be considered a success audiometrically, but who appear to be completely happy with the results. This recent article by Dr. Thurlow and his associates may possibly

explain this phenomenon since their findings reveal that there is an increase of at least 5 decibels more for speech tests than for pure tone tests.

DR. THOMAS M. IRWIN, Jacksonville: It has been my pleasure to see several of the patients Dr. Farrior has mentioned in his report. These patients were examined before going to New Orleans, and audiometric charts were made. Upon their return I have been able to follow their postoperative recovery and again check their hearing acuity under the same circumstances and with the same equipment. To date results have been most gratifying to the otologist, but especially so to the patient.

There are two points in Dr. Farrior's paper that are of particular interest to those doing surgery of the ear. The first is the fenestration operation which has been so adequately discussed by the essayist, and the second is the endaural approach with the employment of the modern technic of mastoid surgery developed by Lempert, Shambaugh, Meltzer and others. It is medically refreshing to see that progress is being made in surgery of the temporal bone.

Stated briefly, some of the advantages of this method of approach are as follows:

1. It offers the most direct avenue of attack on the external auditory canal, the mastoid antrum and cells, the semicircular canals and the cochlea, and also the petrous apex.

2. Bleeding in the endaural incision is usually less than that in the postauricular and is readily controlled by electrocoagulation.

3. Postoperative drainage is perfectly free and direct with the wound left wide open, and retention of secretions cannot occur.

4. After-care is simple, and dressings are not painful.

5. There is no possibility of an unsightly postauricular scar nor of a persistent postauricular fistula.

Endaural surgery is not for the untrained, incompetent, rough or careless operator.

As a word of caution, this operation is not a "cure-all" for all types of deafness, and this fact should be carefully explained to patients who are deaf. If it is not limited to those who have a true otosclerosis, we can expect a larger number of failures and a lower percentage of those who obtain useful hearing.

Florida otologists are happy that Dr. Farrior has returned to Florida, his native state, to continue his good work and add to the prestige of progressive medicine in Florida.

DR. FARRIOR, concluding: I thank Dr. Irwin, Dr. Edwards and Dr. Sayad for their contributions to this paper.

Dr. Sayad has mentioned the dizziness in these patients. This is to be expected in the immediate postoperative period. At the end of the first week, they are able to leave the hospital without great difficulty, and by the end of three to four weeks, there is no significant vertigo.

In summary, I do not have to tell you that, if I had moderate otosclerosis with good inner ear function, I would want a fenestration operation; nor do I have to tell you that, if I had severe otosclerosis with poor inner ear function, I would elect to wear a hearing aid; nor do I have to tell you that I believe the fenestration operation is to be a lasting contribution to otologic surgery.

Cancer Control in Florida

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The 1944 meeting of the House of Delegates of the Florida Medical Association accepted and adopted a report of the Committee on Cancer Control, which read in part as follows: "This committee believes that the cancer control situation in the State of Florida can best be promoted by state legislation which sets aside a definite sum each year for the establishment of cancer clinics for the indigent."

Such an act was proposed in the legislature of 1945 carrying an appropriation of $50,000, but the bill did not pass. This bill was modeled after a law understood to be already in effect in our neighboring state of Georgia, as was suggested by the cancer committee, and under its provisions not only the State Board of Health but also this Association and the American Cancer Society would have had a legal responsibility for the program. This arrangement, however, is not possible under Florida's constitution, which requires that in order to be an officer of the state government and expend state funds one must either be elected by the people or appointed by the Governor. Appropriate changes in the bill were made, and upon the suggestion of the Governor, an appropriation of $200,000 was requested of the 1947 legislature. Before final passage in the spring of last year, the bill had been approved in principle if not in detail by the Board of Governors of this Association, the House of Delegates of this Association and the State Board of Health.

This law, entitled "An Act to promote the prevention and cure of cancer," places a threefold responsibility upon the State Board of Health, and these requirements are outlined in the law title as follows:

State Health Officer
Read before the Florida Medical Association, Seventy-Fourth Annual Meeting, St. Augustine, April 11-14, 1948.

1. "To authorize the Florida State Board of Health to establish a standard for the organization, equipment, and conduct of cancer units or departments in hospitals or in clinics of the State."

2. "To conduct an educational campaign for the control of cancer."

3. "To provide a plan for the care and treatment of indigent persons suffering from cancer."

Some efforts toward cancer control had been carried on prior to the passage of this act. For some time there had been a close working relationship between the State Board of Health and the Florida Division of the American Cancer Society, but our work was for the most part educational in character. In the fiscal year 1946-47, however, about $15,000 was made available to us by the United States Public Health Service for the purpose of cancer control. A small beginning was made with these funds, but, aside from educational work, the most important undertaking was the development of a statewide tissue diagnostic mailing service. This was done in cooperation with the pathologists of the state who agreed to cooperate in a plan to examine specimens for biopsy which were sent directly to them by private physicians. The role of the State Board of Health in this undertaking was to pay a fee for all specimens examined which were certified as being from persons who were medically indigent. This plan has continued in operation.

Properly speaking, however, our cancer control program may be said to have actually started on July 1, 1947, at which time we had available about $200,000 from the state legislature and an additional fund from the United States Public Health Service in the amount of $41,659. Now in common with the general laws of acceleration and momentum our cancer program did not get fully under way on that date, nor is it yet by any means proceeding in the manner and at the rate that we expect it to eventually. It takes time to get anything started, and this program has ramifications which are more intricate and more delicate with respect to our relationships with various groups in the state and particularly with the medical profession than any program that has ever been undertaken by the State Board of Health. There was no particular problem in establishing minimum standards for cancer clinics, as prescribed by the law, since we merely adopted those recommended by the American College of Surgeons. A great deal of time has necessarily been spent in working out a plan for the care and treatment of indigent persons suffering from cancer. It is pointed out that the State Board of Health is not only authorized but directed to make rules and regulations concerning the expenditure of funds for the care of such persons. After much thought the following principles were incorporated into the tentative rules and regulations approved by our Board on Sept. 20, 1947:

1. Funds may only be used for the control of cancer and other malignant tumors; for detection, diagnosis and treatment including hospital care, usually not more than fifteen days, but not for hopeless cases or for terminal care.

2. Funds may not be used to replace or substitute for local funds already appropriated for indigent medical care. This means that if medical care and hospitalization are already provided by a city or county, our funds can be used to improve this service but not to relieve the local body of its financial burden and responsibility, the thought being that the legislature meant for us to seek the improvement of existing services for cancer patients rather than to furnish financial relief to cities and counties.

3. Aid is llmited to medically indigent persons. The responsibility for determining indigence rests with the county health officer, but he is expected to get the assistance of the attending physician and consultants on the case, his professional advisory committee and/or the local welfare agency in making such certifications. In other words, the resources for determining indigence vary so greatly within the state that we leave this matter entirely to local officials to work out. In accordance with the overall policy of the State Board of Health we are prepared to approve any method of determining indigence which a local medical society may recommend to the county health officer.

4. The regulations further provide that recipients must be residents of Florida for at least one year, and forbid payments being made for out-of-state hospitalization or treatment.

5. The original regulations further provided that on or after April 1, 1948 funds shall be expended only on indigent patients who have been routed through an approved cancer diagnostic clinic.

Except for the small sum necessary for bookkeeping and administrative purposes, all available funds have been allotted to the various

counties in the state on the basis of the number of deaths occurring from cancer during the preceding year. We do, however, reserve the right to shift funds from one county to another during the year, when it is apparent that the need is greater in one county than in another.

It was assumed from the wording of the law that it was intended that the State Board of Health should make use of cancer clinics which have met the minimum standards in furnishing aid to the indigent cancer patient. The practice of routing persons suspected of having cancer through cancer diagnostic clinics is now universally practiced in the United States and it is based on the belief that the diagnosis, treatment and management of cancer are not best done by a single physician, or by a single specialist or specialty; that use should be made of the group opinion of the family physician and specialists in the fields of pathology, radiology, surgery, internal medicine, gynecology and other specialties. As a matter of fact, in most of the states now having active cancer programs almost the entire program, except for education and detection, is centered in cancer clinics. We believe, however, that the plan that we have adopted in Florida is the most decentralized, the most flexible and the most sensitive to local needs of any plan in operation in any state in the Union.

It is our belief that the part of our plan requiring patients to be routed through approved cancer diagnostic clinics is an important and fundamental part of the entire program. Such clinics have already been set up in most of the larger centers of population in the state, and they are beginning to function well. In order, however, to give sufficient time for statewide coverage by such clinics, the Board has approved the postponement of this feature of the plan until July 1 and is considering a further postponement until Jan. 1, 1949 upon the recommendation of the Board of Governors of this Association. The reason for the provision of this feature of the plan, as before stated, is that it is necessary in order to provide the best service to the patient by getting the benefit of group opinions. It is not believed that the general practitioner, the surgeon or for that matter any other specialist is individually capable of giving a patient the best chance for recovery through his own individual resources, without the benefit of the advice and consultation of radiologist, pathologist, gynecologist and other specialists, depending upon the location of the lesion.

One of the ever present problems in administering any program furnishing medical services is the amount of the fees to be paid for professional services. The State Board of Health is entirely willing, and in fact anxious and even insistent, that in the final establishment of such fees we have recommendations from this Association to follow. This matter is now being studied by your Committee on Medical Economics, and a formal recommendation on this subject will no doubt be forthcoming soon. Pending a recommendation on this involved subject, we have temporarily adopted the fee schedule in use by the Florida Medical Service Corporation. We have thought that this furnished us with a reasonable temporary expedient. These fees were established for a group of persons in the lower income groups, and since we pay fees for services to medically indigent persons only, we probably are not too far from what is fair and reasonable. I may say here that even with the present somewhat low fee schedule the physicians of the state are being reimbursed for their services much more liberally than in most of the other states of which we have knowledge, and particularly those states neighboring us. There the principle seems to be that the private practitioner should give his services free to the state in connection with medical care of the indigent. I am not sure that this principle is proper. I know of no other group, professional or otherwise, which is asked to give a substantial amount of time or services to a state or local agency without reimbursement. I am rather inclined to think that when a state agency undertakes to arrange services for a group of indigent persons, the medical profession should not be asked to render such services without charge.

Up to this point I have spent most of my time in telling you about the plans of the State Board of Health relative to the cancer program. I shall now briefly outline some of our accomplishments up to date:

During the ten months up to Jan. 1, 1948 in which the tissue diagnostic mailing service has been offered, 302 specimens have been examined. The sites from which these specimens for biopsy were taken were chiefly the cervix, skin and exposed mucous membranes. A limited number of the specimens were removed at operation from internal tumor masses.

The pathologic diagnosis indicated malignant disease in 118 (39 per cent). An additional 32 (11 per cent) were nonmalignant neoplasms. The remaining 152 (50 per cent) were chiefly due to various inflammatory lesions. The predominating malignant tumors diagnosed were basal cell carcinoma and carcinoma of the cervix.

The race and sex of the patients from whom the specimens were removed were as follows:

White males	54
White females	164
Negro males	22
Negro females	55
No data as to sex or race	7
Total	302

The males of both races were chiefly in the older age brackets. The age peak for white females was 30 to 39 years and for Negro females 40 to 49 years.

The patients served resided in fifty of Florida's counties. Polk and Monroe counties used the service more freely than other areas. Considering population, there was a more limited demand from the urban centers where hospital facilities are available for the indigent.

Since inaugurating the general program and up to Jan. 1, 1948 a total of 196 patients with cancer have been approved for state aid in contrast to 248 in the first three months of 1948. Of this number treated for cancer, only 3 have died to date according to the latest information that we have. The locations of cancer in these patients approved for state aid were as follows:

	Males	Females
Gastrointestinal tract	7	8
Genitourinary tract	21	8
Breast	0	31
Uterus, cervix	0	56
Lung	2	1
Bone	4	0
Skin	34	23
Brain tumor	1	0
	69	127
Total	196	

In the total number of cases in which the patient was approved for state aid the following types of services were rendered:

Professional services, operative procedures	52
Hospitalization	39
Roentgen and radium therapy	144

The average amount spent per case was $84.22; however, additional expenditures for radium and roentgen therapy and for hospitalization can be anticipated in many of these cases.

Cancer reporting improved during 1947, but the number of deaths occurring from cancer more than doubled the number of cases reported. During the year there were reported 1,025 cases of the disease, and 2,643 deaths were ascribed to this cause. It is evident that much remains to be done to reduce this appalling death rate and focus more attention on the early diagnosis and treatment of those lesions which later develop into cancer.

During 1947 the cancer program had a good beginning, but in most of the cases approved for state aid the patients had well developed cancer. Our efforts are aimed toward the earlier diagnosis of cancer, and with effective lay and professional education, the death rate from cancer should be considerably reduced.

In addition to the aid rendered to patients themselves, we have continuously carried on the third part of the threefold program, that relating to an educational campaign. Much of this has been directed at lay groups and aimed at getting the patient to the doctor early enough for him to take measures which would give the patient a chance for recovery. In this field of lay education the Florida Division of the American Cancer Society has perhaps done more than the State Board of Health since lay education is a field appropriately worked by a voluntary agency. We have not, however, neglected professional education. Many of you undoubtedly attended the Cancer Seminar held in Jacksonville, Nov. 12, 13 and 14, 1947. The success of this seminar is unquestioned. The State Board of Health is proud to have been able to join with the Florida Division of the American Cancer Society in making it possible. We have also furnished stipends for the training of three physicians in the special technics advocated by Dr. Papanicolaou.

In the larger centers of population where full time personnel is needed in connection with the operation of cancer detection or diagnostic clinics, the State Board of Health has provided funds for the payment of salaries of such personnel as clinic clerks, nurses and social workers. Also in the larger centers of population where cancer clinics are established, our funds have been used for the purpose of purchasing necessary equipment for the better operation of these clinics. The use of state funds for the purchase of equipment and for the payment of salaries of personnel is particularly indicated where there

is a well established city or county hospital and where our funds cannot be used for paying the hospital bills.

I should like to emphasize that our entire program is still a tentative one and that we will be largely guided by the wishes of the medical profession in continuing along present lines. We believe, however, that all will agree that the policy of encouraging local autonomy in the development of local cancer programs and cancer clinics should be continued. Our county health departments and our county health officers are closely integrated into this program, and the county health officers represent the State Board of Health in your counties. We believe that they can be of great assistance to you in the development of your own local program. We hope that if you have problems in your community that you will discuss them among yourselves and with your county health officer and work them out locally in so far as possible.

Should a satisfactory solution to your problems not be found locally, we shall be glad to give every assistance possible from the central office in Jacksonville. We have set up in the Bureau of Preventable Diseases a Division of Cancer Control, which is headed by Dr. James B. Hall. Before Dr. Hall began his duties with us in this capacity, we had him visit the best cancer clinics throughout the East, and he observed not only the method of carrying on the cancer control program in each state that he visited but also the various setups in the cancer clinics themselves. The Division of Cancer Control is a part of the Bureau of Preventable Diseases, which is headed by Dr. R. F. Sondag. He has probably devoted more time than anyone else to working out the details of the plan under which we are now operating in Florida. Needless to say, Dr. Hall, Dr. Sondag and I are available at all times to explain to any local physician or medical society in more detail the Cancer Control Program.

We hope that at least some of the things that we have done and which I have told you about today will meet your approval. Also, we hope that we have gone a little way towards stopping the dreadful menace of cancer that is with us. Most of all, we hope if you differ with us, and here I speak not for myself alone and for the personnel of the State Board of Health and the county health departments but particularly for my Board which establishes all our policies, that you will give us your views freely so that we can work our problems out together in a spirit of good will in order to go forward together in this worthy cause.

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DISCUSSION

DR. JOHN A. BEALS, Jacksonville: Dr. Sowder's paper outlines a somewhat new project. In effect, it represents State Board of Health control over a common, widespread and dreadful disease which is not of communicable type. Florida is not the first state to engage in this experiment in state medicine. The experiment has been well considered, well thought out and placed in operation through the Board of Health by the members of the Florida Medical Association acting officially through the Board of Governors.

I think all of us who have listened to Dr. Sowder's paper know that he is acutely aware of the difficulties and the possibilities for abuse in such a program as this and that he is most anxious that difficulties be ironed out to our satisfaction. We are indeed fortunate in having such a project in the hands of men of the caliber of Dr. Sowder and his co-workers. There may arise many criticisms at the level of origin of the indigent patients seeking or receiving aid by this program. I think I have but one primary thought to emphasize and that is to take advantage of Dr. Sowder's plea; when basis for criticism arises, make it known to him or to his board. In no other way can he know if the project is working out satisfactorily, or if it is being abused. It is a great undertaking which will grow as it succeeds. It could be, in the hands of less medically minded men, something which would not be to the liking of most of us.

The Scientific Department of The Journal

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VOLUME XXXV
NUMBER 1

The Specific Treatment of Pollinosis

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Pollinosis, more frequently referred to as hay fever, regardless of the pollens involved may respond promptly to specific treatment or may tax the patience both of the sufferer and the physician. It should be borne in mind, however, that desensitization to any allergen cannot be carried on hurriedly. Prompt response to treatment means the gradual subsidence of symptoms within four or five weeks. In some instances the period may be shorter, but it is well to advise the patient as to the probable longer period.

This sketch is intended to cover only the definite seasonal reaction and does not include discussion of that vast number of nonseasonal nasal disturbances which are so generally referred to as hay fever. These may be caused by any of the animal hairs, bird feathers, house dust, molds, pyrethrum, orris root and in rare instances foods.

The true pollinosis asserts itself in its victims at a definite season and abruptly departs in much the same manner at another. The patient then remains entirely free of any symptoms whatsoever until the next succeeding season. This is in contrast to the "allergic" nose which gives continual annoyance with recessions and exacerbations having no relation to any season. In the specific pollinosis with no treatment, recurrences occur season after season at approximately the same time of the year. It is not an infrequent occurrence for a person who is allergic to certain pollens to give negative reactions to both the cutaneous and intradermal tests. Such a patient with a definite history of seasonal trouble should be treated with the prevailing pollen of the period corresponding to the symptoms. The same precautions should be taken to guard against possible anaphylactic shock as in those giving positive skin reactions.

The most satisfactory method of desensitizing these patients is by the perennial method, but unfortunately in nearly all instances it is not practical. To keep hay fever sufferers conscious of the necessity of remaining under treatment in the winter months when their trouble does not assert itself until the spring, summer or early autumn seasons is a hard matter. It is consequently difficult to secure the continued cooperation of the patient under these circumstances. Preseasonal treatment is therefore the most practical, but it should commence a sufficient number of weeks in advance of the usual time that symptoms manifest themselves and before the offending pollen appears. Coseasonal treatment is not very satisfactory except in those comparatively few cases in which the patient responds early during the progress of desensitization. Occasionally, 200 to 300 pollen units will start patients on the road to relief, but by far the higher number will require 2,000, 3,000 or even a larger number of units before securing much if any relief.

As desensitization has to be accomplished by commencing with the administration of a few units and gradually increasing them to the point at which the patient will tolerate several thousand, it is essential that treatment be instituted sufficiently in advance of the maximum seasonal production of the pollen being employed for the patient to have become able to tolerate at least 3,000 units. In a general way the degree of sensitivity will govern the maximum number of units tolerated. A commonly employed schedule of dosage is shown in table 1. Doses are administered not less than three or more than four days apart.

TABLE 1

SCHEDULE OF DOSAGE FOR DESENSITIZATION

Dose	Pollen Units	Dose	Pollen Units
1st	5	9th	600
2nd	10	10th	1000
3rd	20	11th	1500
4th	40	12th	2000
5th	60	13th	3000
6th	100	14th	4000
7th	200	15th	5000
8th	400		

This gradual increase in the number of units administered may be safely adhered to provided no excessive local reaction is noted. A red zone at the site of injection the size of a silver dollar should serve as a warning, and the next succeeding dose should not be increased, but instead reduced to 75 per cent of the one previously administered. It is not unusual for a person during desensitization to give a pronounced local reaction at any time during the few weeks it requires to reach the usual maximum number of units. Such a reaction may occur following administration of 100 units or less, or it may not occur until 1,000 or more units is given, the patient then being able to continue on the schedule outlined and a maintenance dose determined upon.

While in most instances a more or less severe local reaction will occur at some point during the scheduled dosage for desensitization, patients are encountered who will complete the schedule with little or no reaction. Any danger of a constitutional reaction is practically nil if local reactions are carefully watched for and the increased dosage given in accordance with the outlined schedule. Occasionally, a patient will not tolerate more than 2,500 or 3,000 units; any attempt to go beyond that dose results in a more or less severe local reaction. This should always be considered as a contraindication to increasing the number of units administered. Having arrived at the maximum tolerated dosage, the patient receives a maintenance dose once or twice weekly, the frequency depending on the prevailing symptoms. The average patient having reached 5,000 units will do well, and complete desensitization will be accomplished on 3,000 units given once or twice weekly. Patients not reaching that maximum should be given about 75 per cent of the maximum number of units reached.

It is essential that the possibility of anaphylactic shock should be kept in mind not only during the period of desensitization but also all during the time the patient is under treatment even though that be prolonged for months. I recall the instance of a young man who went through the schedule of desensitization and had been on a maintenance dose of 3,000 units for several weeks when without warning he went into a violent anaphylactic shock following the routine administration of his customary maintenance dose. The application of a tourniquet above the site of injection and the administration of 10 to 15 minims of adrenalin will in practically all instances overcome this disturbing and alarming reaction.

The common ragweed is probably responsible for as many or more cases of pollinosis as are all other pollens combined. Not infrequently the ragweed victim is allergic to other pollens. With a preseasonal desensitization carried out and a maintenance dose continued until the air is free of the offending pollens, a large number will remain free of trouble during the following years. It is nevertheless not unusual for the patient to become sensitive again by the following season. Two seasons' treatment will generally result in permanent nonsensitivity. There are, however, what may be termed the "pollen fast" cases. In these cases the patient can generally be kept comparatively comfortable by remaining under treatment season after season.

No discussion of the treatment of pollinosis is complete without emphasizing the importance of specific desensitization. In itself, this affliction in the vast majority of cases is not disabling and belongs in the class of what may be termed a nuisance disease. It is not unusual in neglected cases of pollinosis, however, for bronchial asthma to develop later in life.

SUMMARY

The importance of specific treatment of pollinosis is emphasized, and the methods of desensitization are discussed. A schedule of dosage for this therapy is presented. The necessity for being mindful of the possibility of anaphylactic shock throughout the entire period of treatment is stressed, and the not infrequent development of bronchial asthma in later years in neglected cases is mentioned.

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The Journal of The Florida Medical Association

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P. O. Box 1018 (Fla. Theater Bldg.)
Jacksonville 1, Florida

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THE PUBLIC CALLS THE DOCTOR

Some people have complained in recent years that they are unable to see a physician promptly when they are sick, and a few have been particularly loud in their complaints that they are unable to secure the services of a physician for an emergency night call. There are those who believe that a doctor must respond to any call that comes to him, "that he must work all day and half the night and never say he's tired."

That a physician may choose whom he wishes to see as well as what specialty he wishes to pursue would seem to be his prerogative, but it does not follow that he can with impunity become so calloused and unsympathetic that he will not lift his hand to relieve human suffering when it is within his power to do so. The Principles of Ethics cover this point:

> He should . . . always respond to any request for his assistance in an emergency or whenever temperate public opinion expects the service.

This is not really a very difficult point. It is just that now when there is high pressure demand upon the services of physicians, there may arise an occasional case in which there is apparent disregard for the suffering of the individual. Overcrowding of doctors' offices and hospitals makes it difficult to secure a prompt visit even in the office, much more so in the home. The gibe of Groucho Marx, "make an appointment with the doctor and probably you'll see him in two or three days," is not at all exaggerated. Actually, it is not unusual to have to wait two or three weeks to see a specialist in internal medicine for a diagnostic survey or even for evaluation of a serious cardiac complaint when much more prompt study would be highly advantageous.

When we are dealing with human commodities, it is hard for some to see the overall perspective clearly and unbiasedly. Many can understand that if a theater is sold out for a performance, there just are no more seats, but it is much more difficult for them to see why a physician cannot see every sick person who applies to him for help.

Let's look at it this way. If a specialist in internal medicine applies himself assiduously to his work, he builds a reputation that stimulates many ill persons to seek his services. The quality of his work, however, demands that he spend considerable time with each patient. He takes a careful history, examines at length, makes thorough clinical studies, spends time in evaluating all of the findings and finally with patience and finesse attempts to explain to the patient the significance of the studies. Sometimes it is necessary to tell the patient of impending death, but much more often he must decide how best to tell the patient that really there is nothing

much wrong. Most patients who present diagnostic problems are time-consuming if they are handled well. Obviously not many of them can be seen in the course of a day. Sir William Osler is reported to have said that no diagnostician should try to see more than four new patients per day. Accordingly, they have to be scheduled in advance.

The physician has to decide whether he prefers to spend less time with each patient and see more, or spend more time with each and see fewer. It is true that the patient or prospective patient often may become distressed and even loud in his complaints if he is not seen promptly, but he may have a much more valid complaint if he is seen promptly, but inadequately.

Likewise, a physician has the right to say whether he wishes to see patients in their homes and whether he wishes to make night calls. The internist is apt to be less efficient with his diagnostic studies, and the surgeon is unlikely to operate with his usual facility and skill if he has lost sleep because of night calls. Here again, however, each should use judgment and not fail to respond in an emergency when "temperate public opinion expects the service."

Better organization of the medical profession to meet the demands of the ill appears to be in order. Many young physicians, while establishing themselves in practice, are not only willing but eager to make night calls. County medical societies could maintain physicians' telephone exchanges, which will locate physicians who are willing to make night calls. Young physicians could receive calls from older physicians through these exchanges. Likewise, these bureaus could furnish the names of specialists when such service is requested.

Good public relations between the profession and the public cannot be stressed too much. Most physicians do the best that they can with their mental and physical endowments, but in order to give more adequate service to the sick, better organization and better public relations are necessary.

NATIONAL HEALTH ASSEMBLY ECHOES

An unexpected note of harmony marked the close of the National Health Assembly, called early in May by Federal Security Administrator Oscar R. Ewing as an initial step in setting up, at the instigation of President Truman, a ten year health program for the nation. Instead of resulting in a scrap, the bristling distrust among the eight hundred representatives of labor, farm, public health, cooperative parent-teacher groups and organized medicine simmered down to surprising accord. It appeared that areas of agreement were much greater than had been anticipated.

Variously reported as window dressing, a $45,000 show, a lot of talk and a constructive approach to the problem of national health, one member opined that the gathering caused about as much noise nationally as "a ray of moonlight falling on a cup of custard." No new voices were added in behalf of socialized medicine since the last health assembly was held ten years ago. The American physician and organized medicine fared well, doubtless in large measure because of persistent watchfulness and able representation.

The most controversial single issue before the assembly was that of voluntary group health plans versus compulsory government-administered plans. The embattled medical care section of the assembly finally agreed on seven points, but came to no agreement on this eighth point. Both consumer and medical sides of the controversy indorsed extension of voluntary cooperative health insurance plans, but consumer groups, including labor and cooperatives, advocated compulsory national health insurance as "an immediate goal." Spokesmen for these groups repeatedly singled out the American Medical Association for criticism, but the heat of sharp discord was tempered by the tolerance, understanding and mature viewpoint of the minority representatives trained and experienced in professions requiring discipline and sacrifice.

In a fair and impartial report to the assembly of the proceedings of the fourteen panels, Quincy Howe of the Columbia Broadcasting System paid particular tribute to the American Medical Asso-

ciation, concluding with this statement: "That so many doctors not only have taken the time to work with the National Assembly but have shown themselves so cooperative, so understanding, so open-minded, seems to me the most promising and the most important development of this whole meeting."

At a press conference Mr. Ewing announced that he would make his report to the President in about a month. He reiterated his personal view that the health needs of the nation can be met only by some form of compulsory health insurance. Since the findings of the assembly are in no way binding upon him, this opinion will probably be strongly reflected in his report.

LEST WE FORGET

Lord God of Hosts, be with us yet,
Lest we forget—lest we forget!
Kipling's Recessional

American Independence Day, commemorating freedom from the rule of Britain, makes tragic history this year for the medical profession of that country. On July 4, 1948 our British colleagues stand to lose their life and death struggle for their freedom and independence, for the National Health Service Act providing universal free medical service is scheduled to take effect on July 5.

In a plebicite 89 per cent of the members of the British Medical Association voted against accepting the service. Its delegated representatives, in positive and unanimous agreement, then refused to participate in manning the state-insured medical service. They vociferously defied the Labor government to force them to accept service under the Health Act until changes were made to "maintain the integrity of medicine and prevent doctors being turned into state servants."

The delegates emphasized their refusal by setting aside an "independence fund," initially of $1,600,000, to aid physicians who render medical service and are unable to collect sufficient fees to maintain their independence. Too, they condemned "what looked like organized political and trade union pressure on doctors to join the service."

Heated controversy prevails in the press and in Parliament. The chief objection voiced in the medical press is the vast power vested in the Minister of Health, amounting to a dictatorship which robs the profession of its freedom. Too, there is the fear that the basic salary of $1,200 proposed for all physicians will lead to full-blown state medicine with all physicians getting all their pay from the government.

On the other hand, as commented on editorially in the May Journal, the government and its press ignore the overwhelming vote of the younger members and berate the reactionary "old gentlemen of the British Medical Association" for obstructing a most beneficent reform worthy of worldwide emulation. They also decry political dislike of the Labor Party.

In theory physicians may elect to participate in the plan or remain in private practice, but with nationalization of all hospitals included in the plan, they must have government approval for hospitalization of patients and become dependent on the state for drug supplies and medical equipment. Too, how many Britons will be willing to pay the physician in addition to paying their insurance tax?

It behooves the members of organized medicine in this country to study with great care the situation of the medical profession in a changing world, as represented by these happenings in Great Britain. Let us not forget that a like situation could develop here.

Even now the thunder of propaganda for federal control of medicine reverberates louder and louder from within the framework of the government in a determined and persistent effort to manufacture a demand that does not exist. In the increasing tempo of our fight against the tyranny of bureaucratic control of such a personal service as medical practice, we shall stem the tide only if we, too, like our British confreres, with dignity and pride in our attainments as individuals steadfastly 'refuse to be reduced to ciphers on the state payroll.'

BLUE SHIELD—BLUE CROSS ACTIVITIES

At their semi-annual meeting in Los Angeles late in March Blue Shield and Blue Cross plans reached agreement on the forming of a joint executive committee. It will consist of six members, equally divided between the two commissions.

As chief executive officer for these two plans, Dr. Paul R. Hawley will be solely responsible to the joint executive committee on all matters of mutual concern to both organizations. Blue Shield and Blue Cross recognize the advantage to be gained in securing jointly the leadership of such an outstanding administrator as Dr. Hawley, former medical director of the Veterans Administration. This merging of interests in the mutual employment of an executive officer does not, however, change the status of either organization. For his convenience, both staffs will occupy a common location in Chicago.

Dr. Hawley assumed office on April 1, 1948, and one of his first official duties was representing Blue Shield and Blue Cross at the National Health Assembly, held in Washington the first week in May. He served on the executive committee and was one of the principal speakers in the section on medical care.

In this largest of the fourteen panels there were two hundred and eight members registered and among them eighteen physicians. His role was to take middle ground in the heated controversy on contributory health insurance. The principle was endorsed by all factions, but the kind became the big issue.

In his advocacy of the voluntary insurance plans as the expedient course between "free enterprise" on the one hand and compulsory national health insurance on the other, he contended that Blue Cross and Blue Shield, if properly developed and extended, can enable the people to prepay their medical costs while avoiding the disadvantages of socialized medicine. He cited as proof their rapid recent growth with the number of members at that time approximately thirty-eight million and the Blue Shield membership increasing 3,500 per cent in eight years.

No definite conclusion on this issue was reached. Nevertheless, Dr. Hawley announced: "This has been an extremely important meeting, at which the demands of large consumer groups were set forward forcibly. They cannot be ignored by medicine or the voluntary prepayment agencies. Their demands have to be met. . ."

NUTRITIONIST AND PHYSICIAN RESEARCH IN NUTRITION

Perhaps better than any other profession, medicine illustrates the interrelation of the scientific professions. Without making constant use of a practical knowledge of pharmacy, chemistry, physics and nutrition as well as kindred sciences the physician could not practice.

The nutritionist is peculiarly fitted to aid the practitioner of medicine. His contribution in establishing the nutritional values of foods is invaluable both in the restoration and in the maintenance of health. In relation to disease his investigations are equally as important. The physician keeps a wary eye upon reports of studies on nutrition in relation to cancer and is ever mindful of the association of pellagra with the consumption of high proportions of whole ground cornmeal. Milk protects against caries, meat promotes formation of hemoglobin and red blood cells in infants, ascorbic acid requirements for pregnant and lactating women, newly isolated vitamin B_{12} effective against nutritional anemia, pernicious anemia and tropical sprue—so run a few of the recent headlines chosen at random recounting explorations for more precise knowledge regarding diet essentials for all ages.

As for ascorbic acid requirements, at the moment the strawberry is in the medical limelight. Investigators[1] declare that it is an important source of vitamin C. Prominent varieties grown in the South average about 50 mg. of ascorbic acid per hundred grams of berries for about half of the national crop. In some varieties grown in the Pacific Northwest the content of this vitamin averages between 75 and 80 mg.

Authorities estimate that the probable average of 60 mg. for the country's entire crop could be increased up to 80 mg. or more by breeding.

In the war-torn countries, nutritionists[2] report, strange edibles proved to be good sources both of vitamins and minerals and of much-needed proteins and fats. The wheat and other grains available were ground whole for human use or milled to high rates of extraction. All skim milk, whey, organ meats and in places even the blood of slaughterhouse animals were consumed.

In Norway, sea gulls, crows, strange fish, dandelions, nettles, acorns, leaves and nuts all had their uses, and the countryside was fine-combed for mushrooms and berries. In Russia, a paste rich in carotene, made from inedible greens, was spread upon bread, and pomegranate was boiled and concentrated. In Holland, plasma from slaughterhouse blood was fed to famine victims, at first cooked in pancakes, later as bouillon or in brown bean soup.

Who knows but that the germ of genuine world peace lies hidden in a grain of wheat multiplied to assuage world hunger? Whatever awaits the epicure in the many herbs, ferns, palms, grasses, tuber seeds and fruits that are unusual foods of high nutritive value, the nutritionist continues his quest for their health-giving disease-combating secrets for the benefit of all mankind.

1. Ezell, Boyce D.; Darrow, George M.; Wilcox, Marguerite S., and Scott, D. H.: Ascorbic Acid Content of Strawberries, Food Research, vol. 12, November-December, 1947.

2. Wilder, Russell M., and Keys, Thomas E.: Foods for Emergencies, J. A. M. A. 136:323-327 (Jan. 31) 1948.

IRON MEN OF MEDICINE
"20,000 YEARS OF SERVICE"

If a medical Methuselah had broken the record for longevity by some nineteen milleniums, he would have become a disciple of Aesculapius several thousand years back in the Paleolithic era, long before the time of historical records. But in the whole two hundred centuries he could not have witnessed the progress in medicine that the last fifty years have brought. That in 1947 some four hundred living physicians who had in one state practiced for half a century or more should present the composite picture of twenty thousand years of service to humanity is a matter of moment.

At its annual meeting last year the Medical Society of the State of New York awarded a certificate to four hundred and thirty-two physicians of that state who had practiced medicine for fifty years or more in recognition of their efforts and as a token of appreciation "for the commendable feat of bridging the years in this most arduous of callings." A Fifty Year Club was organized to perpetuate this recognition.

In addition, a commemorative booklet, titled "20,000 Years of Service," is now off the press. To scan it with its interesting photographs of these veterans is both an inspiration and a benediction. Forty-eight supplied photographs taken at the time they began the practice of medicine as well as recent ones. One of two who had practiced seventy years was still practicing orthopedics at ninety.

That these men of idealism and rare resourcefulness retain keen interest in the world about them is exemplified in their hobbies—travel, music, art, writing, yes, and raising minks and chasing fires. They recount receiving as fees in lieu of legal tender such diverse items as a bag of river eels, a recipe for "moonshine," a kicking horse, a baby and a piano, not to mention a quarter of beef.

The Medical Society of the State of New York is to be congratulated on paying honor to whom honor is due in this gracious manner. In acknowledging the citation for himself and the other recipients, Dr. Nathan B. Van Etten, dean of New York medicine, said in part: "We are glad that we have survived our strenuous years and that we have practiced medicine in a distinctly modern age. Excepting vaccination against smallpox all of modern medicine is included within the period from 1894 to 1947. . . We are old and we are not sad about it. The lines on our faces are the etchings of experience. You may have the fruits of our experience for the asking, but I warn you old folks are loquacious and you must be patient."

PHYSICIANS' SECRETARIES AND THE BLUE SHIELD

The Florida Medical Association started and organized the Blue Shield Plan and presented the first contracts to the public on Sept. 1, 1946. The funds needed to start this nonprofit corporation were raised through individual contributions from the physicians and the county medical societies. The needed funds were readily raised because the profession realized the need for such a plan. The public realizing that the physicians had organized the Blue Shield Plan to help them meet the hazards of catastrophic illnesses willingly accepted the plan. In the short time that has followed, fifty thousand persons in Florida have been enroled in the Blue Shield Plan. That alone is proof that the public has accepted it.

There is a doubt, however, as to whether or not member physicians and their secretaries have accepted the plan. Numerous complaints have been made by members of the Blue Shield Plan who upon contacting their physicians are surprised to find out that the physician and/or secretary is not familiar with the Blue Shield. This is, indeed, discouraging to say the least. Many physicians have signed agreements to participate in the plan, likewise many have advanced funds to get the plan started and then have neglected to explain the details of the Blue Shield Plan to their secretary and receptionist.

A physician's secretary is an important cog in the machine. If the secretary understands what the physicians are trying to do with the Blue Shield and if the secretary understands the details of the Blue Shield, the plan, which is the profession's answer to proponents of compulsory health insurance, can be furthered. If the secretary knows that a single patient who is earning less than $2,000 a year, or a family who is earning less than $3,000 a year, that you have signed an agreement to furnish the services covered by the plan for the fees set forth in the Fee Schedule, she then would be in a position to properly handle and assist the patients with their financial responsibility for services.

When our representatives sell the public our contract and state it will do certain things, the physicians who are participating in the Blue Shield Plan must see to it that their part of the contract is kept in force. The Blue Shield Plan has forwarded to all of its participating physicians a card to be placed on the receptionist's desk, reminding the subscriber to present his identification card at the time he is making arrangements for this care. Do you have that card displayed in your office? Have you instructed your secretary to ask each patient at the time that she is obtaining the vital information so necessary to you, such as name, address, and so forth, if he is a member of the Blue Shield Plan? The time to find this out is at the time financial arrangements are being made. If at this time there is a doubt as to whether or not the patient is in the low income group and therefore entitled to full coverage, the patient should be prompted to substantiate the fact that he is in the low income group. If the patient's income exceeds the $2,000 and $3,000 brackets as mentioned above, regular charges for services are made and the payment from the plan is applied as a credit against the physician's charge. These and many other suggestions could be given to the physician's secretary. The plan and the physician would be benefitted.

Educate your secretary to the Blue Shield Plan.

PROBLEMS OF THE CHRONICALLY ILL

Chronic illness affects nearly every family in the United States. Chronic diseases are those that may be expected to require an extended period of medical supervision with the patient receiving care in a hospital or an institution with nursing. Most important among them are cardiac diseases, arteriosclerosis, hypertension, nervous and mental diseases, tuberculosis, renal diseases, diabetes and asthma.

As many as twenty-five million persons, more than one sixth of the population, are reportedly subject to some one of the diseases named. Almost a million deaths occur annually as a result of chronic diseases, and at least a billion days of productive work are lost through chronic disabilities. Half a century ago one person in twenty-five was 65 years of age or older, but the life span has gradually been extended for more and more people until today it is estimated that 10 per cent of the population is over 65 years of age. Chronic diseases are, however, not necessarily diseases of the aged. Of chronically ill persons, at least one half are below the age of 45 and 16 per cent are under 25 years of age. Particularly challenging are the problems of children, such as those chronically ill with rheumatic fever.[1]

Partial solution of the problems of this large segment of the population lies in research. Research projects on renal diseases, arteriosclerosis, malaria and cirrhosis of the liver are already under way, and the National Institute of Health is subjecting cardiac disease, cancer and mental disease to special research. So important have the chronic diseases become that they demand the most intensive study.

Facilities for the care of the chronically ill should be planned not merely for the indigent, as is often the case, but for the community as a whole. Too, hospitals for these patients should probably be situated near medical schools and teaching hospitals rather than in suburban or rural areas in order to make the medical advice and the associated laboratories of these institutions readily available for application to their care and to the solution of their problems. The major emphasis in caring for these patients should be directed to returning them to useful life in the community.

For patients with tuberculosis and mental disease there is of course special provision, but little has been done for those who suffer from some of the other diseases. In eight states and four cities of the North official action is being taken toward solving the problem.[1] To secure adequate knowledge of the need and to develop plans for progress in meeting the need of the chronically ill, complete cooperation and coordination of the many agencies now concerned with such persons and their diseases are essential. When departments of health, welfare and education, medical societies, medical schools, hospitals, social agencies, rehabilitation services and institutions for this large and important group work together to a common end, then and then only will their problems be solved.

1. Fishbein, Morris: The Chronically Ill—An Editorial, Hygeia 26:17 (Jan.) 1948.

SOUTHEASTERN SURGICAL CONGRESS

The sixteenth annual Southeastern Surgical Congress' Post Graduate Assembly was held in the Hollywood Beach Hotel at Hollywood, April 5-8, 1948. Registration showed 651 surgeons from Southeastern states in attendance, many accompanied by their wives.

The program consisted of forty-four papers, diversified and intended to be an all-inclusive refresher course. Among the distingished surgeons and outstanding medical authorities who presented lectures were Dr. George M. Curtis, Columbus, O., Dr. Frederick F. Boyce, New Orleans, Dr. William Langley Sibley, Roanoke, Va., Dr. Harry E. Bacon, Philadelphia, Dr. Claude J. Hunt, Kansas City, Dr. Fred W. Rankin, Lexington, Ky., Dr. Charles W. Mayo, Rochester, Minn., Dr. Herman L. Kretschmer, Chicago, and Dr. Samuel F. Marshall, Boston. Dr. Frank K. Boland of Atlanta, Ga., reviewed the history of medical progress, and Dr. Horace G. Smithy of Charleston, S. C., who earlier this year became the first surgeon in medical history to remove scar tissue from the heart valves, also presented a paper.

Dr. Herbert Acuff of Knoxville, Tenn., president, addressed the congress on the opening night. He was succeeded in office at the close of the session by Dr. Gilbert F. Douglas of Birmingham, Ala.

Dr. Walter C. Jones of Miami, general chairman of arrangements, and Dr. Edward Jelks of Jacksonville, welcomed the surgeons. The chairman of the entertainment committee, Dr. Joseph S. Stewart of Miami, then president-elect of the Florida Medical Association, presided at the banquet. Dr. Robert T. Spicer, president of the Dade County Medical Association, and many physicians of the greater Miami area cooperated by serving on the various committees, thereby helping to make the assembly the notable success that it was.

SEMINAR ON VD TREATMENT

More than one hundred and fifty delegates registered for the two day seminar on the treatment of venereal disease with penicillin and streptomycin, held at the Roosevelt Hotel in Jacksonville on April 7 and 8, 1948. Physicians and public health officials from New Mexico, Oklahoma, Texas, Louisiana, Arkansas, Tennessee, Mississippi, Alabama, Georgia and Florida attended.

The purpose of the seminar was to evaluate the effectiveness of penicillin and streptomycin in venereal disease control, to consider recent developments in the use of and research on these drugs and to discuss case-finding technics. In addition to the scientific approach to treatment with these newer drugs, other subjects featured on the program were strengthening the

educational approach, interstate control, a report on the blue star research program, the progress of mass blood testing in Alabama, and the use of nonmedical personnel in the administration of the program. There was a symposium on the treatment of known contacts.

Among the country's leading authorities who addressed the gathering were Dr. R. A. Vonderlehr, former chief of the venereal disease control division, United States Public Health Service; Dr. Evan Thomas, New York University, a leader in research into the use of penicillin for treatment of venereal disease, Dr. J. F. Mahoney, chief, venereal disease research laboratory, Staten Island, N. Y., the first to use penicillin for this therapy, Dr. Robert Greenblatt, University of Georgia, and Eric Barnow of the National Broadcasting Company. Welcoming the delegates and also participating in the discussions were Dr. Wilson T. Sowder, state health officer, Dr. R. F. Sondag, Bureau of Preventable Diseases of the State Board of Health, and Dr. W. W. Rogers, city health officer.

BCG VACCINATION POLICY

The first official statement of the American Trudeau Society, Medical Section of the National Tuberculosis Association, on BCG (Bacillus Calmette-Guerin) and its use declares that vaccination with BCG does not provide complete protection against tuberculosis and, until further controlled studies are conducted, cannot be recommended for the general population. This statement was published in the March issue of the National Tuberculosis Association Bulletin and also in the April number of the American Review of Tuberculosis.

Since BCG appears, however, to provide some degree of protection, it is recommended for members of certain groups if they are subjected to more than ordinary exposure to tuberculosis provided they do not react to adequate tuberculin tests. These groups include physicians, medical students and nurses; hospital and laboratory personnel whose work brings them in contact with the bacillus of tuberculosis; persons who are unavoidably exposed to tuberculosis in the home; and patients and employees of mental hospitals, prisons and other custodial institutions among whom the incidence of tuberculosis is known to be high.

When prepared under ideal conditions and administered to tuberculin-negative persons by approved technics, the vaccine is regarded as harmless. Nevertheless, it is not advocated that it be made available for widespread distribution at present because (1) the most effective strain of BCG has not been determined nor has satisfactory standardization of the vaccine been achieved, (2) the best qualified experts have not agreed as to the most effective vaccination procedure to employ, and (3) fully satisfactory arrangements have not been perfected for transportation and storage of the vaccine.

Emphasis is placed upon the importance of not regarding BCG vaccination as a substitute for approved hygienic measures nor for public health practices designed to prevent or minimize tuberculous infection and disease. It is only to be accepted within the limitations outlined as one of many procedures to be used in the control of tuberculosis.

MEDICAL OFFICERS RETURNED

Dr. Joseph Weinreb, who entered military service Oct. 20, 1940, received his discharge on March 8, 1946. His address is 21 Catherine St., Worchester, Mass. He held the rank of Lieutenant Colonel.

Dr. Thomas L. Roberts, Jr., who entered military service March 5, 1941, received his discharge on Jan. 26, 1947. His address is 322 Blount Building, Ft. Lauderdale. He held the rank of Captain.

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PUBLIC RELATIONS

Legislative matters have priority billings in many programs of organized medicine for the present and for any foreseeable future. This status holds true on national, state and local levels. Next spring the Florida state legislature meets. Whether private enterprise, sound public health measures and the best medical service in the world withstand certain attack by proponents of compulsory health measures depends upon how well and accurately informed legislators are previous to that time.

The legislative program of the Association is in the process of formation. Policies and procedures to be followed during the coming year are being given serious consideration by the Committee on Legislation and Public Policy, under the direction of Dr. W. Duncan Owens, Miami Beach, chairman.

Its decisions are certain to be predicated upon anticipated assistance by the legislative committees of the various county societies. Local physicians can provide their own legislators with factual information which will enable them to make intelligent decisions on matters pertaining to public health and medicine generally.

In this connection Bay County Medical Society followed a procedure which should produce tangible results. The lawmakers who will represent Bay County in the next session of the state legislature were invited to a meeting of the society. The legislators assured the physicians that their opinions on health and medical measures would be sought and given serious consideration. Actually, what was said at the meeting was probably rather insignificant compared to the value received from their getting better acquainted. Each group will understand the other better. This is public relations at work.

Manatee County Medical Society has something of the same nature on its program. Probably neither society knew the plans of the other. It is interesting that both should arrive at similar conclusions on how best to serve the public and the medical profession.

Marion County Medical Society has a smoothly functioning public relations program. The A.M.A. electrically transcribed programs available from the Academy of Public Medicine are being used. These are greatly enhanced and supplemented with additional "live" programs, the doctors themselves going on the air. The press is kept well informed. Since all this is done in conjunction with the county health department, duplication and possible contradiction are avoided. Dr. Richard C. Cumming, Ocala, is the chairman of the public relations committee.

At their meeting in St. Augustine the Board of Governors authorized a telegram to be sent to the Florida members of the Congress in Washington protesting the proposed peacetime drafting of physicians. This action has caused considerable favorable editorial comment from the newspapers of the state.

On the national level two recent events have definite public relations significance. The National Health Assembly in Washington, called by Federal Security Administrator Oscar R. Ewing, apparently did not terminate in the revival of positive agitation for a compulsory program at this time, as was anticipated by many observors.

Doctors of the country showed their unselfish public spirit to the nation in the recent meeting in Chicago to consider plans for organization of a medical relief program in case of national emergency. This session was given wide news coverage by the press associations and radio commentators. Favorable editorial comment followed in the newspapers and on the air. Medical public relations took a long step forward.

BIRTHS AND DEATHS

BIRTHS

Dr. and Mrs. Edward Gonzalez, Key West, announce the birth of a son on April 22, 1948.

Dr. and Mrs. Edward C. Watt, Jacksonville, announce the birth of a son, Edward Clements, Jr., on April 15, 1948.

Dr. and Mrs. Cecil B. Brewton, Fernandina, announce the birth of a son, Cecil Bart, Jr., on April 24, 1948.

Dr. and Mrs. John H. Mason, Jr., Miami, announce the birth of a son, John Bradford, on April 6, 1948.

Dr. and Mrs. Marcus B. Bergh, Jacksonville, announce the birth of a son on May 18, 1948.

Dr. and Mrs. Stanley Frehling, Miami, announce the birth of a son, James, on April 16, 1948.

Dr. and Mrs. Charles L. Shalloway, Miami Beach, announce the birth of a son, David Irwin, on April 6, 1948.

DEATHS—MEMBERS

Dr. Ben D. Spears, Wauchula ..... April 25, 1948
Dr. John D. Peabody, Asheville, N. C..... May 30, 1948
Dr. Perry C. Farnell, Branford ..... June 5, 1948

DEATHS—OTHER DOCTORS

Dr. Walter M. Brunet, Brooklyn, N. Y.....Sept. 24, 1947
Dr. Allen R. Howard, North Attleboro, Mass...June 4, 1947
Dr. Charles N. Harper, New York, N. Y. ..December, 1947
Dr. Frank E. Kellner, Rome, N. Y..... Dec. 25, 1947
Dr. Thomas J. Kemp, St. Louis ..... January, 1947
Dr. Theodore Lamson, Miami ..... Oct. 20, 1947
Dr. George A. Lassman, New York, N. Y.....April 21, 1947
Dr. Edward A. Stapleton, Albany, N. Y..... June 11, 1947
Dr. Alonzo H. Waterman, Chicago ..... Nov. 26, 1947
Dr. Joe S. Riley, St. Petersburg..... May 16, 1947
Dr. William M. Goodson, Panama City..... May 27, 1948
Dr. John Halliday, West Palm Beach ..... April 28, 1948

STATE NEWS ITEMS

Dr. Benjamin F. Dickens has opened offices in Fernandina for the practice of medicine and surgery.

Twenty-four members of the Florida Medical Association were present at the organizational meeting of the Florida Obstetric and Gynecologic Society which was held on April 11, 1948 in St. Augustine. Dr. Chas. J. Collins of Orlando was elected president; Dr. Robert G. Nelson, president-elect, and Dr. Dorothy D. Brame, secretary-treasurer. The society plans to invite nationally recognized speakers to its annual meetings. All members of the Florida Medical Association interested in joining this organization should communicate with Dr. Brame, 1235 Kuhl Avenue, Orlando.

The Southeastern Section of the American Urological Association has at its disposal a fund which is to be used to stimulate research on the problem of "Urinary Bladder Dysfunction." The fund of $1,000 was donated by Mr. and Mrs. William R. McEwen of Ft. Lauderdale. An award of $250 will be made for the best essay presented before the annual meeting of the section in Boca Raton in March. The competition is open to physicians who have been graduated from medical school during the last ten years. Further information may be obtained from Dr. Russell B. Carson, Secretary-Treasurer, 408 Sweet Building, Ft. Lauderdale.

In observance of National Hospital Day, May 12, Dr. Theodore J. Kaminski of Melbourne presented a short address on the Brevard Hospital over the local radio station WMMB.

Dr. Stanford Setnor has moved his offices from Tallahassee to Daytona Beach. He has opened his offices at 318 Seabreeze Boulevard for the practice of medicine and surgery.

Dr. Victor A. Hughes, who plans to resume private practice in Jacksonville soon, spoke recently at the annual Tri-City Meeting of the St. Louis, Chicago and Kansas City Gynecological and Obstetrical Societies. His subject was "Carcinoma of the Cervix." For the past three years Dr. Hughes has been doing postgraduate work at Barnes and St. Louis Maternity Hospitals in St. Louis, where he is now resident obstetrician and gynecologist.

The youngest member of the Blue Shield family of plans, as reported on May 1, 1948, was Chicago Medical Service, in which approximately 12,500 members were enroled during the first two weeks of this first enrolment in Chicago. This was the fifty-second member plan in Associated Medical Care Plans, the national association of Blue Shield plans.

Drs. Orion O. Feaster and Annette M. Feaster of St. Petersburg announce their retirement from the practice of medicine June 1. They wish to thank their friends for their loyalty throughout the years.

Physicians who practice in counties bordering on the Suwannee River met in Lake City on May 14. The Suwannee River Medical Society was addressed by Dr. John A. Beals, president of the Duval County Medical Society and Chief of the Radiologic Department of St. Luke's Hospital in Jacksonville. Dr. Beals discussed "The Uses and Limitations of Roentgen Examinations." Several physicians on the staff of the Veterans Administration Hospital in Lake City were guests at the meeting.

Dr. S. Marion Salley of Miami has returned from Boston where he attended the thirty-fifth reunion of the staff of the Peter Bent Brigham Hospital.

Dr. Robert B. McIver of Jacksonville was the guest speaker at the May meeting of the Polk County Medical Society which was held in Lakeland. He spoke on "The Fused Kidney."

Dr. Joseph W. Scott, formerly of the University Hospital, Iowa City, Iowa, now is associated in the practice of obstetrics and gynecology with Dr. Ralph W. Jack of Miami. Their offices are located at 1700 Biscayne Boulevard.

Dr. Newell J. Griffith, formerly of Cleveland, now is associated with Drs. Wiley T. Simpson and Ivan W. Gessler in their practice in Winter Haven. Dr. Griffith recently completed a four months' postgraduate course in internal medicine and pediatrics at New York Postgraduate School.

Dr. William P. Blackmon of Apalachicola has been received into membership of the Franklin-Gulf County Medical Society. His address is P. O. Box 157.

COMPONENT SOCIETY NOTES

BREVARD

The May meeting of the Brevard County Medical Society was held at the Florida Rapid Treatment Center in Melbourne. The physicians of the Florida State Health Department at the center were hosts. A number of unusual syphilitic lesions were demonstrated on patients at the center. Dr. John A. Barger, chief medical officer, presented a paper on the diagnosis and treatment of syphilis. Drs. John O. Rao and A. F. Reiter of Osceola County were guests at the meeting.

BROWARD

The 1948 dues have been received from the entire membership of the Broward County Medical Society.

ESCAMBIA

At the regular meeting of the Escambia County Medical Society which was held at the Pensacola Country Club on May 11, members of the military service of the United States Naval Hospital and Naval Air Training Bases and from Eglin Air Field were guests of the society. Dr. George W. Morse presided.

Dr. Joseph W. Douglas introduced the guest speaker, Dr. J. H. Collins of the Department of Obstetrics and Gynecology, Tulane University School of Medicine. Dr. Collins presented a paper on the "Papanicolaou Technic for Cancer Detection in Body Fluids."

The business meeting was held a week later on May 18 at the San Carlos Hotel. Dr. Joe I. Turberville, president, conducted the meeting. Dr. John J. McGuire, chairman of the Cancer Control Clinic, reported 220 patients had been examined and 20 cases of cancer diagnosed during the past six months. A plea was made for increased interest through monthly conferences and presentation of cases.

Dr. Walter C. Payne reported that the Medical Edition of the News Journal, sponsored by the society, would be published on June 13.

Members were informed by a communication from the commanding officer of the 265th coast artillery battalion, N. G., that physicians and dentists who would be subject to the proposed selective service act of 1948 could be exempt by joining the local N. G. unit which has vacancies for one medical and one dental officer.

HILLSBOROUGH

Dr. James J. Callahan, Professor of Bone and Joint Surgery, Loyola University, Chicago, presented a paper on "Shoulder Lesions" at the May meeting of the Hillsborough County Medical Society.

INDIAN RIVER

All members of the newly formed Indian River County Medical Society have paid Association dues for 1948.

JACKSON

Jackson County Medical Society members have completely paid 1948 Association dues.

LEE

All members of the Lee County Medical Society have paid their Association dues for 1948.

MANATEE

Members of the Manatee County Medical Society have paid 1948 dues to the Association.

MARION

Dr. Henry L. Harrell reported for the Marion County Medical Society delegates to the Florida Medical Association at the society's April meeting. Present at the meeting were Drs. William H. Anderson, Jr., Hugh H. Barfield, Richard C. Cumming, Bertrand F. Drake, Henry L. Harrel, Carl S. Lytle, William J. McGovern, Robert E. Thompson and Henry F. Watt of Ocala; Dr. Carroll T. Bowen of Bronson; Dr. William H. Garvin, Jr., of Dunnellon; Dr. Edwin C. Hanson of Belleview; Dr. Herbert M. Webb, Jr., of Wildwood.

MONROE

Monroe County Medical Society dues are 100 per cent paid for 1948.

NASSAU

Drs. John M. McDonald and Benjamin F. Dickens were elected to membership in the Nassau County Medical Society at its April meeting. It was decided at that time to meet regularly on the last Friday night of each month.

PINELLAS

The Pinellas County Medical Society held its June fellowship hour, dinner and meeting at the Army and Navy Club of St. Petersburg with Dr. M. Eldridge Black presiding. In the future, meetings will be held at the Bahama Shores Yacht Club and after the July meeting members will convene on the first Monday of the month.

Dr. H. Milton Rogers presented a paper on "Congenital Heart Disease" and introduced a patient. He was assisted in his presentation by Drs. John H. Cordes, Jr., and John P. Ferrell.

Dr. Black expressed the appreciation of the society to Drs. Orion O. and Annette M. Feaster who recently have retired from medical service.

Dr. Lamar L. Knight and Dr. Julio J. Guerra were the principal speakers at the May dinner meeting of the society. They spoke on hypertension and cancer reports.

AUGUSTUS EUGENE CONTER

Dr. Augustus E. Conter of Apalachicola died on April 12, 1948, of a heart ailment from which he had been suffering for some time. He was 76 years of age.

Dr. Conter was born in Baden, Germany, and came to the United States at the age of 18 to study music. After several years in this country he entered Emory University and on April 4, 1902, he received his medical degree from the Atlanta College of Physicians and Surgeons. He received postgraduate work at Polyclinic in New York and Tulane University.

Among Dr. Conter's possessions is a certificate, dated March 31, 1903, which granted him the privilege of practicing medicine in the Territory of Oklahoma. From 1914 to 1918 he served as chief physician at the Florida State Hospital at Chattahoochee. He was a member of the Franklin-Gulf County Medical Society, a member of the Florida Medical Association which he served as a necrology committee member, and the American Medical Association.

He had served in the Spanish American War, the Florida Troops and the National Guard Medical Reserve Corps. Dr. Conter was a charter member of the local council of the Knights of Columbus.

He is survived by his wife, Mrs. Mary Ann Conter, and a daughter, Miss Alice Marie Conter, both of Apalachicola; another daughter, Mrs. Bernard F. Benning of New Orleans; and a son, Charles A. E. Conter of Troy, Ala.

HARRY LEWINGTON MERRYDAY

Dr. Harry L. Merryday, veteran physician of Daytona Beach, died on March 28, 1948, in Riverside Hospital, Jacksonville, following a heart attack. He was 62 years of age.

Dr. Merryday was born in Palatka in 1884, the son of Mr. and Mrs. W. A. Merryday, who were prominent in the business circles of Palatka. In 1914 Dr. Merryday was married to Sallie K. Walton of Gallatin, Tenn.

He was graduated from the University of Louisville School of Medicine in 1914 and was licensed to practice medicine during the same year. Dr. Merryday received postgraduate courses at the Harvard Medical School in Boston. He was a member of the Volusia County Medical Society, the Florida Medical Association and was a fellow of the American Medical Association. He was a past president of the Halifax District Hospital staff.

Dr. Merryday was a charter member of the Daytona Beach Rotary Club, a member of the selective service advisory board and a past director of the Daytona Beach Chamber of Commerce.

In addition to his widow, he is survived by a daughter, Martha, and a son, Harry, of Daytona Beach, and a brother, Harlow, of Palatka.

JOHN HENRY THOMAS

Dr. John Henry Thomas of Gainesville died on April 9, 1948, of acute pancreatitis. He was in attendance at the Southeastern Surgical Congress at Hollywood, Fla., when taken ill and died in the Jackson Memorial Hospital in Miami. He was 40 years old.

The son of the late Major W. R. and Katherine Kraus Thomas, a prominent pioneer family of Gainesville, Dr. Thomas, was born on Sept. 13, 1908. He was a lifelong resident of Gainesville and a graduate of the local high school and the University of Florida. He was enroled at the Jefferson Medical College of Philadelphia from which he received his degree in 1935. Dr. Thomas served his internship at the Jackson Memorial hospital in Miami. Since 1937 he had lived and practiced in Gainesville where he was a staff member of the Alachua County Hospital.

Dr. Thomas was a member of the Alachua County Medical Society, the Florida Medical Association which he served as a member of the venereal disease committee, and the American Medical Association. He also was a member of the Alpha Sigma Medical fraternity, the H. A. Hare Medical Society, the Schaeffer Anatomical Society, the Bauer Pediatrics Society and the Aero-Medico Association.

He is survived by three children, Anne, Penelope and Priscilla Thomas, two brothers, Clarence S. and Philip E. of Gainesville, and a sister, Mrs. Samuel W. Hawkins of Atlanta.

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HILLSBOROUGH AUXILIARY RECOGNIZED

The Hillsborough County Medical Society Auxiliary is one of the newest in the state and its outstanding work is recognized in Tampa's monthly magazine, First, from which the following is quoted:

"To take recognition of those legions of brave and unselfish women who daily are performing great service to all of us in the community, First will nominate in each issue our 'Woman of the Month!' Service to the community will be the determining factor in these selections. Our first 'Woman of the Month' is Mrs. E. F. Shaver, wife of a prominent Tampa physician. This issue contains the story of Mrs. Shaver and the work being done among spastic paralytics by the organization of physicians' wives of which she is president."

Mrs. C. D. Rollins
Editorial Chairman

HILLSBOROUGH COUNTY MEDICAL AUXILIARY MEETING

A recent meeting of the auxiliary was conducted by Mrs. Edward F. Shaver with a record number of members in attendance. Mrs. Kenneth G. Gould read the delegate's report concerning the state convention.

The auxiliary, taking as its project the Bayside School of Spastic Children and the Lomax Orthopedic Class, the first school for crippled Negro children in Hillsborough County, has given 621 hours of service to the spastic schools. Auxiliary members work in close cooperation with the Bayside School staff giving practice steps for physiotherapy purposes, and collecting and contributing various needed articles. The children were also given a Christmas party and an Easter egg hunt. Members also have assisted in Red Cross, Community Chest, Tuberculosis X-Ray Survey, and Crippled Children's drives.

Mrs. C. Frank Chunn was appointed chairman of a special committee for collecting and sending discarded journals, medicines and surgical supplies to the Overseas Medical Relief Committee. Mrs. Herschel G. Cole, Mrs. John R. Boling and Mrs. David R. Murphey, Jr., presented completed plans for a barbecue and entertainment to be given in honor of Doctors on Doctor's Day.

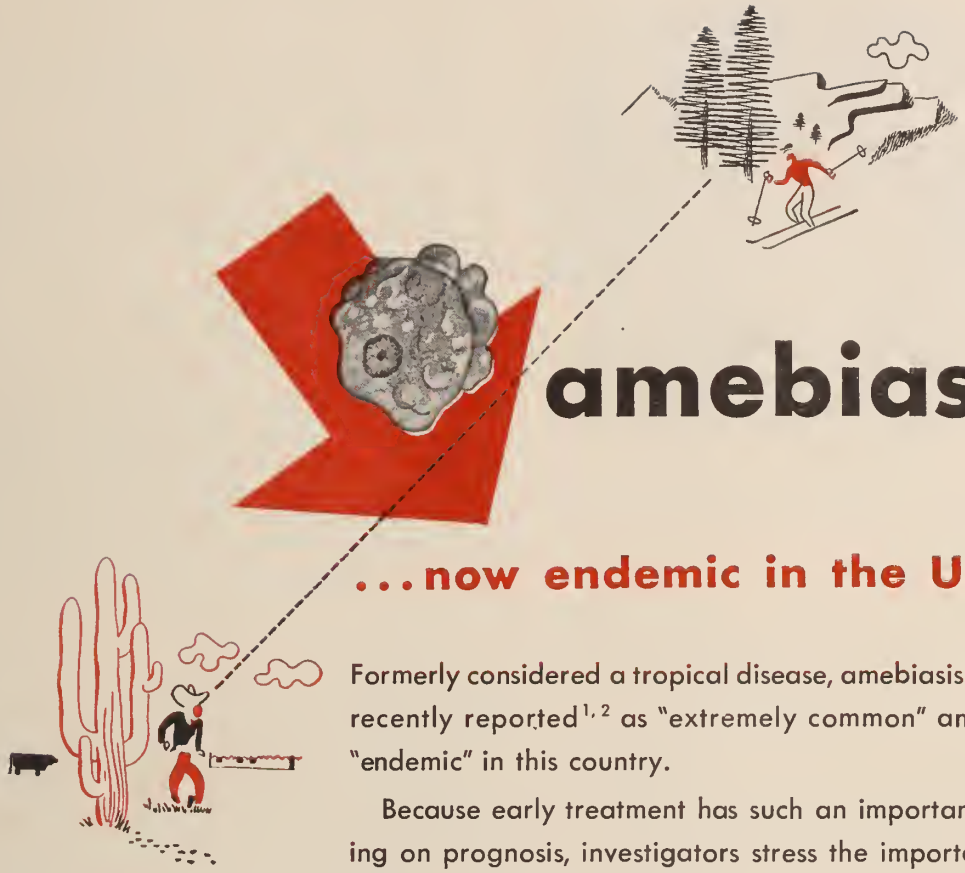
Mrs. Harold O. Brown presented Dr. Joshua C. Dickinson who introduced the guest speaker, Mrs. Malcolm Smith. She spoke on cancer control.

A luncheon was served and the meeting was adjourned.

Mrs. Ann F. Massaro, Secretary

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RESEARCH
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1. Chalgren, W. S., and Baker, A. B.: Tropical Diseases: Involvement of Nervous System, Arch. Path. 41:66 (Jan.) 1946.

2. Browne, D. C.; McHardy, G., and Spellberg, M. A.: Statistical Evaluation of Amebiasis, Gastroenterology 4:154 (Feb.) 1945.

3. Mansan-Bahr, P.: Some Tropical Diseases in General Practice: "A Post-War Legacy," Glasgow M. J. 27:123 (May) 1946.

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From where I sit
by Joe Marsh

How to Live Longer

Someone asked Pappy Miller last week how he stayed so spry at ninety. Pappy told him:

"Well, sir—when I work, I work hard. When I set, I set loose. When I think, I go to sleep."

According to Doctor Hollister, that formula isn't far amiss. "Hard work," he says, "never wore out anyone before his time, providing he knew how and when to relax."

Hollister himself works overtime, with his daytime patients at the office, and his evening calls. And when he gets home he takes it easy with a mellow glass of beer and chats with the missus until it's time to go to bed.

From where I sit, relaxing is certainly a fine art—especially in these tense, fast-moving times. And there's nothing just quite like a temperate glass of beer—enjoyed with pleasant company—to restore that easy frame of mind that one really needs after a hard day's work.

Joe Marsh

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BOOKS RECEIVED

HISTORY OF THE MEDICAL SOCIETY OF THE COUNTY OF WESTCHESTER 1797-1947. By Laurance D. Redway, M.D., Pp. 193. New York: Medical Society of the County of Westchester, 1947.

As a feature of the Sesquicentennial Celebration of the Medical Society of the County of Westchester, in the state of New York, a history of the society was prepared by its historian, Dr. Laurance D. Redway. This compilation from the available minutes and various contemporary sources during the years for which the minutes were lost elaborates upon the sketch prepared by the preceding historian for the one hundred and twenty-fifth anniversary celebration and also covers the period from 1922 to 1947. This record of the landmarks of progress and accomplishment of this society is a valuable contribution to the annals of medicine. Anticipating the American Medical Association by no less than half a century, this early county society started with eight members and now has over one thousand.

PSYCHOBIOLOGY AND PSYCHIATRY, A TEXTBOOK OF NORMAL AND ABNORMAL HUMAN BEHAVIOR. By Wendell Muncie, M.D. Ed. 2. Price, $9.00. Pp. 620 with 70 illustrations. St. Louis: The C. V. Mosby Company, 1948.

This valuable textbook is the first comprehensive and authoritative presentation in book form embodying the teachings of Dr. Adolf Meyer and coming out of the Johns Hopkins University and the Phipps Psychiatric Clinic. It is now organized in three parts. They cover the concept of psychobiology and the fundamentals of human behavior; the pathology of human behavior, including a discussion of the Meyerian terminology; and the treatment of abnormal behavior reactions.

This second edition has been extensively edited in the light of what the author has found useful as concepts and as practice in the recent years during which psychiatry has been put to the severest tests. His approach embodies the Meyerian ideals: "Know thy neighbor as thyself; give new ideas a chance; cultivate a sense of history!" The practicality of the volume is reflected in the author's statement in the preface: "As a practitioner, it has been my constant effort to test theory and to strip from my service to patients the academic chaff of words, cliches, and hallowed traditions. The living sufferer in the consulting room reduces the most minute history and the most treasured concepts, by comparison, to a desiccated, boneless mass unfit even for statistics."

Thus in one comprehensive text are offered the essential tools with which to work out the many and varied problems of mentally disturbed and disorganized patients.

THE BATTLE OF THE CONSCIENCE, A PSYCHIATRIC STUDY OF THE INNER WORKING OF THE CONSCIENCE. By Edmund Bergler, M.D. Price, $3.75. Pp. 296. Washington: Washington Institute of Medicine, 1948.

That everyone harbors an inner conscience and is constantly under its influence is the intuitive and consoling belief of humanity, abundantly confirmed by psychiatric-psychoanalytic research. The basis of this book rests upon the conclusion that every human action and reaction, in so far as it is influenced by the uncon-

scious, contains a large element of this unconscious inner conscience.

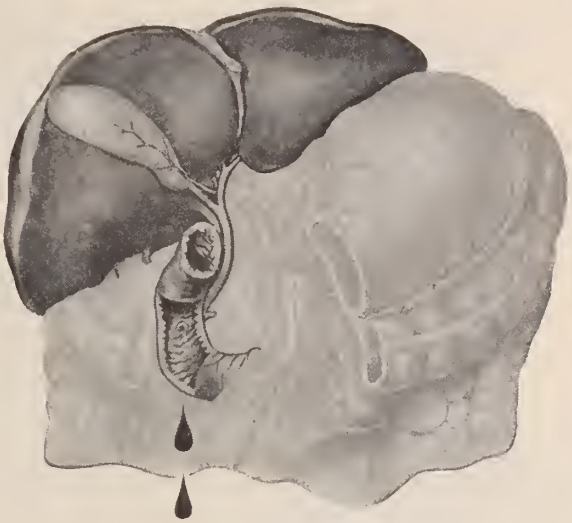
The author describes the devious unconscious bargains with which three groups of persons—the normal, the neurotic and the criminotic—appease their inner consciences. He depicts unconscious conscience as a force so dynamic as to be the decisive part of the personality and not at all identical with conscious precepts popularly misunderstood as the whole conscience. In it he finds the guide to success or failure, happiness or depression, love or loneliness.

Advances in Military Medicine Made by American Investigators Working Under the Sponsorship of The Committee on Medical Research. Price, two volumes, $12.50. Pp. 900. Boston: Atlantic—Little, Brown, 1948.

This two volume work, the fourth in the series on Science in World War II giving the history of the Office of Scientific Research and Development, describes the achievements of medical men and their associates in research, the tremendous effects of which are now beginning to be felt throughout the fields of medicine and public health. This official record of medical progress during the war tells how some 1,700 physicians and 3,800 scientifically trained researchists associated with the Committee on Medical Research were mobilized for the battle against disease and injury, what they did and how they did it, and—of greater importance perhaps—what yet remains to be accomplished.

The members of the Committee on Medical Research who edited this story of the specialists in the respective fields of study and activity are: Medicine, Dr. E. Cowles Andrus, Johns Hopkins Hospital; Surgery, Dr. John S. Lockwood, Columbia University; Aviation Medicine, Dr. Detlev W. Bronk, University of Pennsylvania; Physiology, Dr. Joseph T. Wearn, Western Reserve University; Chemistry, Dr. Milton C. Winternitz, Yale University; Malaria, Dr. George A. Carden, Jr., Columbia University; and Penicillin, Dr. Chester S. Keefer, Massachusetts Memorial Hospitals. There is a complete bibliography, and the list of all OSRD medical research contracts contains the names of hundreds of teams of physicians and allied scientists who carried on the vast campaign in hospitals, laboratories and field camps.

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*Albrecht, F. K.: Modern Management in Clinical Medicine, Baltimore, The Williams and Wilkins Co., 1946, p. 170.

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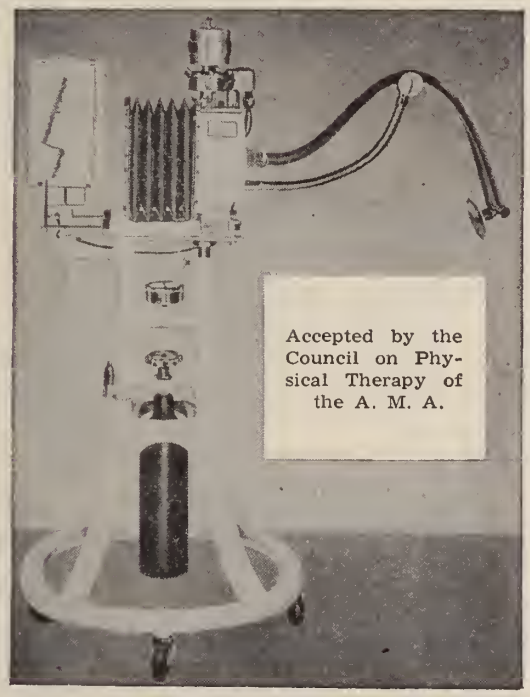
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1. Downing, J. G., Hanson, M. C. and Lamb, M.: Use of 5-Nitro-2-Furaldehyde Semicarbazone in Dermatology, J.A.M.A. *134*:299, 1947 • **2.** Robinson, H. M. and Robinson, H. M., Jr.: The Comparative Values of Some New Drugs in the Pyodermas, South. M. J. *40*:409, 1947 • **3.** Miller, J., Rodriquez, J. and Domonkos, A.: Evaluation of Penicillin in Topical Therapy, New York State J. Med. *47*:2316, 1947 • **4.** McCollough, N. C.: Treatment of Infected War Wounds with a Nitrofuran. Indust. Med. *16*:128, 1947.

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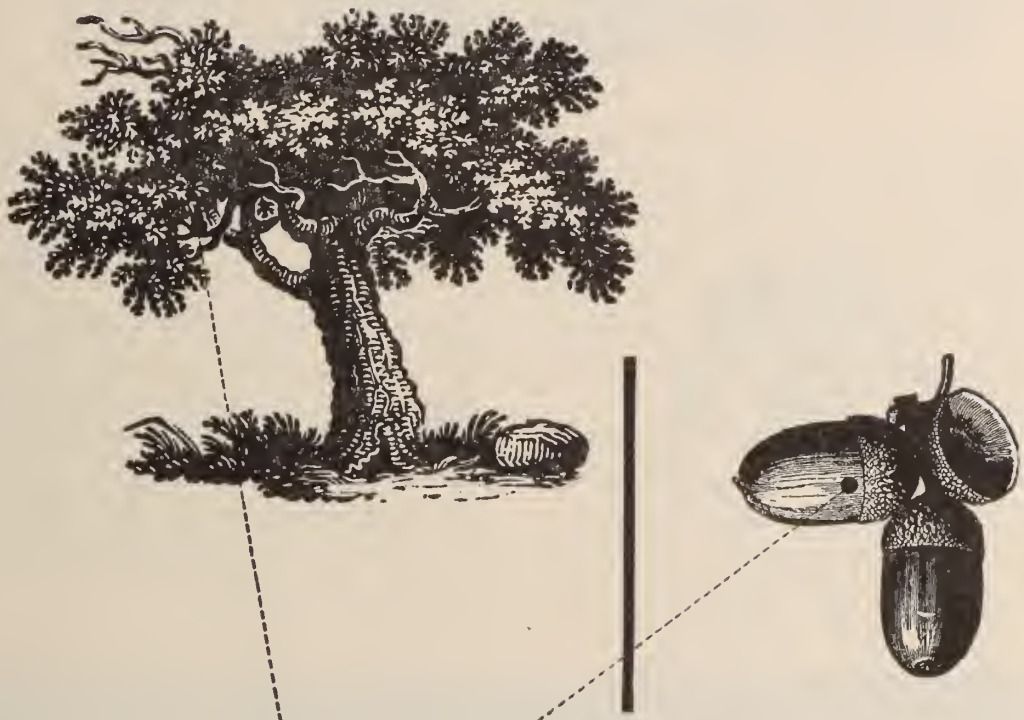
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	SOCIETY	PRESIDENT	SECRETARY	MEETING DATE	MEMBERS Total	MEMBERS Paid	COUNCILOR
A	Bay	William C. Roberts, M.D. 348 Cove Blvd. Panama City	Russell T. Stewart, M.D. 224 East 4th St. Panama City		13	9	
	Escambia *Santa Rosa*	Joe I. Turberville, M.D. Century	Nathan S. Rubin, M.D. 5 E. Gregory St. Pensacola	2nd Tuesday 8:00 P.M.	61	58	
	Franklin-Gulf	T. Meriwether, M.D. Wewahitchka	J. R. Norton, M.D. Port St. Joe	3rd Tuesday Odd Months	7	4	A-1-50 William P. Hixon, M.D. Pensacola
	Jackson *Calhoun*	Courtland D. Whitaker, M.D. Burton Bldg. Marianna	Francis M. Watson, M.D. 120 Deering St. Marianna	3rd Thursday 7:30 P.M.	15	100%	
	Walton-Okaloosa	Ralph B. Spires, M.D. DeFuniak Springs	Arthur G. Williams, Sr. Lakewood	3rd Thursday 8:00 P.M.	13	100%	
	Washington-Holmes	N. J. Dawkins, M.D. Vernon	B. W. Dalton, M.D. Chipley		5	100%	
B	Columbia *Baker-Hamilton*	W. M. Ives, M.D. 20 W. Madison St. Lake City	Thomas H. Bates, M.D. 27 W. Madison St. Lake City	1st Monday 7:30 P.M.	14	100%	
	Leon-Gadsden-Liberty-Wakulla-Jefferson	Taylor W. Griffin, M.D. Quincy	Edward C. Love, Jr., M.D. Masonic Temple Bldg. Quincy	Quarterly 7:30 P.M.	45	40	A-2-49 Irby H. Black, M.D. Live Oak
	Madison-Suwannee	C. LeRoy Adams, Jr., M.D. Parshley Bldg. Live Oak	Irby H. Black, M.D. 918 W. Howard St. Live Oak		7	100%	
	Taylor *Dixie-Lafayette*	Walter J. Baker, M.D. Foley	Ralph J. Greene, M.D. Perry	Last Friday 8:00 P.M.	4	100%	184
	Alachua *Bradford, Gilchrist Union*	J. Maxey Dell, Jr., M.D. 331 W. Main St., S. Gainesville	F. Emory Bell, M.D. Box 400 Gainesville	2nd Tuesday 8:00 P.M.	34	33	
	Duval *Clay*	John A. Beals, M.D. 1900 Boulevard Jacksonville	Elmer E. Leitner, M.D. 33 W. Ashley St. Jacksonville	1st Tuesday 8:15 P.M.	239	227	
	Marion *Levy*	Hugh H. Barfield, M.D. 1317 S. Orange St. Ocala	Bertrand F. Drake, M.D. Professional Bldg. Ocala	3rd Wednesday 12.30 P.M.	31	25	B-3-50 Charles C. Grace, M.D. St. Augustine
	Nassau	David G. Humphreys, M.D. Fernandina	John W. McClane, M.D. Fernandina	Last Friday 8:00 P.M.	10	9	
	Putnam	Edward W. Ford, M.D. Crescent City	James W. Davidson, M.D. 6 S. Main St. Crescent City	2nd Tuesday 6:00 P.M.	8	7	
	St. Johns	Hardgrove S. Norris, M.D. 168 Marine St. St. Augustine	S. Raymond Cafaro, M.D. Exchange Bank Bldg. St. Augustine	3rd Tuesday 8:30 P.M.	15	100%	
C	Brevard	I. Kimbell Hicks, M. D. Melbourne	Theodore J. Kaminski, M.D. Box 576 Melbourne	2nd Tuesday	15	13	
	Lake *Sumter*	Howard G. Holland, M.D. 1112 W. Main St., Leesburg	Matthew Arnow, M.D. Eustis	1st Wednesday 7:30 P.M.	24	21	B-4-49 Rabun H. Williams, M.D. Eustis
	Orange *Osceola*	Rollin D. Thompson, M.D. Box 3513 Orlando	James G. Economon, M.D. 108 E. Central Orlando	3rd Wednesday 8:00 P.M.	132	128	
	Seminole	Harry Z. Silsby, M.D. Box 642 Sanford	Frank L. Quillman, M.D. Box 158 Sanford	2nd Tuesday 5:30 P.M.	11	100%	
	Volusia *Flagler*	Charles E. Tribble, M.D. DeLand	Robert L. Miller, M.D. 258½ S. Beach St. Daytona Beach	2nd Tuesday 7:30 P.M.	51	50	570
D	Hillsborough	Douglas D. Martin, M.D. 442 W. Lafayette St. Tampa	Herschel G. Cole, M.D. 315 Wallace S. Bldg. Tampa	1st Tuesday 8:00 P.M.	142	139	
	Manatee	Millard P. Quillian, M.D. Walcaid Bldg. Bradenton	Willett E. Wentzel, M.D. Professional Bldg. Bradenton	3rd Tuesday 7:00 P.M.	18	100%	C-5-49 John M. Butcher, M.D. Sarasota
	Pasco-Hernando-Citrus	William G. Mason, M.D. Inverness	W. Wardlaw Jones, M.D. Box 247 Dade City	2nd Thursday 7:00 P.M.	14	13	
	Pinellas	M. Eldridge Black, M.D. 311 Coachman Bldg. Clearwater	Whitman C. McConnell, M.D. 313 First Federal Bldg. St. Petersburg	1st and 3rd Thursdays 6:30 P.M.	158	155	
	Sarasota	John M. Butcher, M.D. 209 Commercial Ct. Sarasota	Talmadge S. Thompson, M.D. Box 224 Venice	2nd Tuesday 8:30 P.M.	23	22	
	DeSoto-Hardee-Highlands-Charlotte-Glades	Zaven M. Seron, M.D. Sebring	Howard V. Weems, M.D. 22 Oak St. Sebring	2nd Tuesday 8:00 P.M.	25	24	
	Lee *Collier, Hendry*	Harvie J. Stipe, M.D. 210 Richards Bldg. Ft. Myers	H. Quillian Jones, M.D. 311 Professional Bldg. Ft. Myers	3rd Tuesday 7:30 P.M.	22	100%	C-6-50 H. Quillian Jones, M.D. Ft. Myers
	Polk	Chester H. Murphy, M.D. Bartow	John W. Vaughn, M.D. Box 475 Lakeland	2nd Wednesday 7:00 P.M.	73	69	475
	Indian River	James C. Robertson, M.D. Vero Beach	William L. Fitts, 3rd, M.D. Vero Beach Arcade Vero Beach	2nd Tuesday 8:00 P.M.	8	100%	
	Palm Beach	Victor Clarholm, M.D. Box 672 West Palm Beach	Ralph M. Overstreet, Jr., M.D. 820 Comeau Bldg. West Palm Beach	3rd Monday 8:00 P.M.	87	83	D-7-50 Erasmus B. Hardee, M.D. Vero Beach
	St. Lucie-Okeechobee-Martin	Hugh B. Goodwin, Jr., M.D. Arcade Bldg. Ft. Pierce	Adrian M. Sample, M.D. Box 176 Ft. Pierce	3rd Thursday 8:00 P.M.	13	11	
	Broward	Milton N. Camp, M.D. 720 Sweet Bldg. Ft. Lauderdale	Alva R. Taylor, M.D. 414 Blount Bldg. Ft. Lauderdale	4th Tuesday 8:00 P.M.	64	100%	
	Dade	Robert T. Spicer, M.D. 1110 Huntington Bldg. Miami	Benjamin G. Oren, M.D. 628 duPont Bldg. Miami	1st Tuesday 8:30 P.M.	479	443	D-8-49 Russell B. Carson, M.D. Ft. Lauderdale
	Monroe	James B. Parramore, M.D. 523 Whitehead St. Key West	Herman K. Moore, M.D. 811 United St. Key West	2nd Thursday 8:00 P.M.	11	100%	662

*Councilor until organized separately

Total 1,891

SCHEDULE OF MEETINGS

ORGANIZATION	PRESIDENT	SECRETARY	ANNUAL MEETING
Florida Medical Association	Joseph S. Stewart, Miami	Robert B. McIver, Jacksonville	Belleair, 1949
Florida Medical Districts	Herman Watson, Lakeland	Council Chairman	
A-Northwest	Irby H. Black, Live Oak	William P. Hixon, Pensacola	Live Oak, 1948
B-Northeast	Rabun H. Williams, Eustis	Charles C. Grace, St. Augustine	Daytona Beach, 1948
C-Southwest	John M. Butcher, Sarasota	H. Quillian Jones, Ft. Myers	Bradenton-Sarasota, 1948
D-Southeast	Russell B. Carson, Ft. Lauderdale	Erasmus B. Hardee, Vero Beach	West Palm Beach, 1948
Florida Specialty Societies			
Derm. and Syph., Soc. of	A. Buist Litterer, Miami	Wesley W. Wilson, Tampa	
Genl. Practice of Med.	M. Crego Smith, Clearwater	Walter E. Murphree, Gainesville	
Health Officers' Society	Roger F. Sondag, Jacksonville	Lorenzo L. Parks, Jacksonville	
Industrial & Railway Surgeons	F. Hardy Bowen, Jacksonville	J. H. Mitchell, Jacksonville	
Neurology & Psychiatry	James G. Lyerly, Jacksonville	William H. McCullagh, Jacksonville	
Ob. and Gynec. Society	Chas. J. Collins, Orlando	Dorothy D. Brame, Orlando	
Ophthal. & Otol., Soc. of	Bascom H. Palmer, Miami	W. Jerome Knauer, Jacksonville	
Orthopedic Society	Charles B. Mabry, Jacksonville	Eugene L. Jewett, Orlando	
Pathological Society	James N. Patterson, Tampa	Gretchen V. Squires, Pensacola	
Pediatric Society	Edgar W. Stephens, W. P. Beach	Hugh A. Carithers, Jacksonville	
Proctologic Society	Dean W. Hart, St. Petersburg	Frederick E. Farrer, Miami	
Radiological Society	James F. Pitman, Lake City	Floyd K. Hurt, Jacksonville	
Urological Society	Milton M. Coplan, Miami	Russell B. Carson, Ft. Lauderdale	
Florida—			
Academy, Public Medicine	Robert T. Spicer, Miami	Shaler Richardson, Jacksonville	
Basic Science Exam. Board	Paul A. Vestal, Winter Park	M. W. Emmel, D.V.M., Gainesville	
Dental Society, State	Horace L. Cartee, D.D.S., Miami	John I. Todd, D.D.S., Jacksonville	Hollywood, Dec. 12-15, 1948
Hospital Association	Mr. James T. Pate, Jacksonville	Mr. H. A. Schroder, Jacksonville	
Hospital Service Corporation	Mr. W. E. Arnold, Jacksonville	Mr. H. A. Schroder, Jacksonville	
Medical Examining Board	Frank D. Gray, Orlando	H. D. Van Schaick, Miami	
Medical Postgraduate Course	Turner Z. Cason, Jacksonville	Chairman	
Medical Service Corporation	Leigh F. Robinson, Ft. Lauderdale	Herbert E. White, St. Augustine	
Nurses Association, State	Miss Elizabeth Reed, Jacksonville	Helen Shearston, Miami	West Palm Beach, Fall, 1948
Pharmaceutical Association, State	Mr. D. M. Weaver, Miami	Mr. R. Q. Richards, Ft. Myers	
Public Health Association	Wilson T. Sowder, Jacksonville	Mr. Fred B. Ragland, Jacksonville	Panama City, Oct. 7-9, 1948
Tuberculosis & Health Assn.	Mr. Lacy G. Thomas, Groveland	Mr. E. W. Crouch, Foley	
Woman's Auxiliary	Mrs. L. E. Parmley, Winter Haven	Mrs. C. R. Morgan, Jr., Miami	Belleair, 1949
American Medical Association	Edward L. Bortz, Philadelphia	Geo. F. Lull, Chicago	
Southern Medical Association	E. L. Henderson, Louisville, Ky.	Mr. C. P. Loranz, Birmingham	Miami, Oct. 25-28, 1948
Alabama Medical Association	J. Paul Jones, Camden, Ala.	Douglas L. Cannon, Montgomery	Montgomery, Ala., Apr. 19-21, 1949
Georgia, Medical Assn. of	Edgar Hill Greene, Atlanta	Edgar D. Shanks, Atlanta	Savannah, Ga., May 10-13, '49
S. E. Hospital Conference	Mr. Frank Groner, New Orleans	Mr. Burton M. Battle, New Orleans	Biloxi, Miss.
Southeastern Allergy Assn.	J. Warrick Thomas, Richmond, Va.	Kath. B. MacInnis, Columbia, S. C.	
Southeastern, Am. College Phys.	Webster Merritt, Jacksonville	Florida Program Chairman	Atlanta, 1948
Southeastern Am. Urological Assn.	Harold P. McDonald, Atlanta	Russell B. Carson, Ft. Lauderdale	Boca Raton, March, 1949
Southeastern Surgical Congress	Gilbert Douglas, Birmingham, Ala.	B. T. Beasley, Atlanta	

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AUG 1948

The JOURNAL of the Florida Medical Association, Inc.

Vol. XXXV AUGUST, 1948 No. 2

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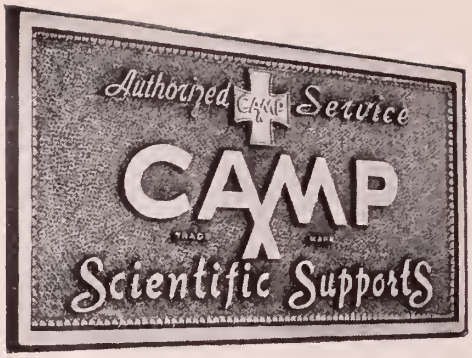
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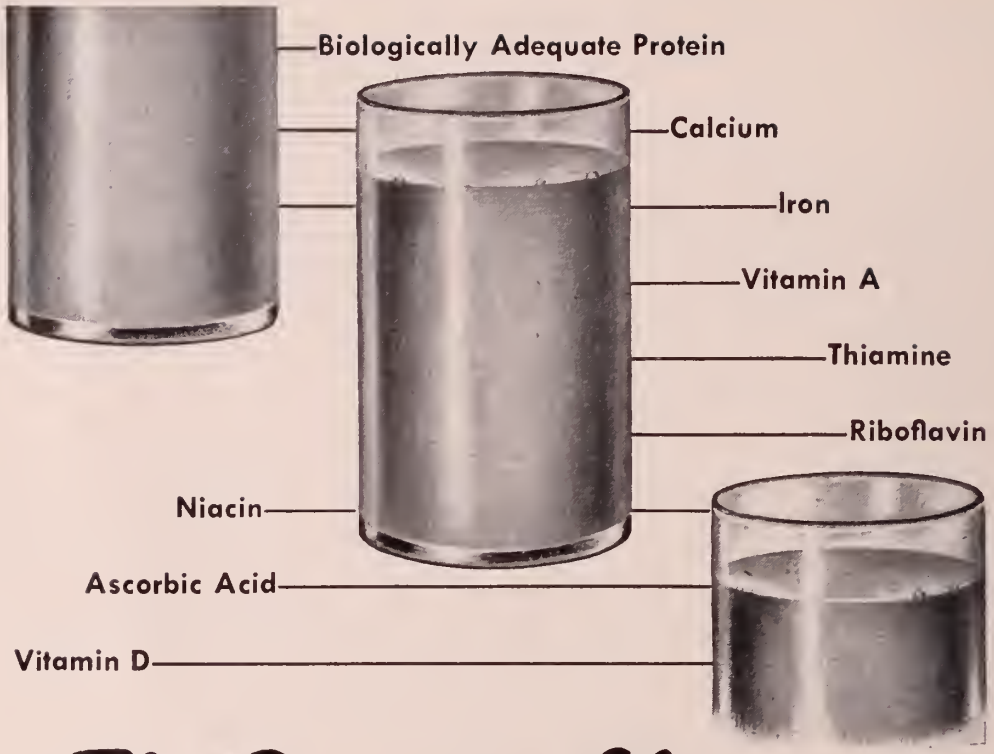
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This Journal is not responsible for the opinions and statements of its contributors.

Published monthly at Jacksonville, Florida. Price $5.00 a year; single numbers, 50 cents. Address Journal of the Florida Medical Association, P. O. Box 1018 (Fla. Theater Bldg.), Jacksonville 1, Fla. Telephone 5-0577. Accepted for mailing at special rate of postage provided for in Section 1103, Act of Congress of October 3, 1917; authorized October 16, 1918. Entered as second-class matter under Act of Congress of March 3, 1879, at the post office at Jacksonville, Florida, October 23, 1924.



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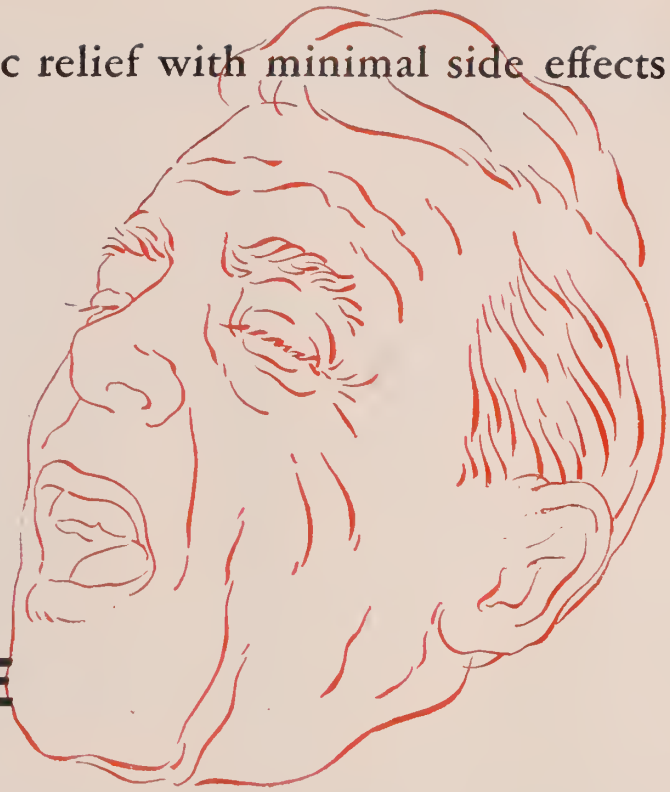
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1. Arbesman, C. E.: *N. Y. State Jl. of Med.*, 47: 1775, 1947.
2. Loveless, M. H.: *Am. Jl. of Med.*, 3: 296, 1947.
3. Bernstein, Rose and Feinberg: *Ill. Med. Jl.*, 92: 2, 1947.
4. Osborne, Jordon and Rausch: *Arch. of Derm. & Syph.*, 55: 318, 1947.

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BY JULIO DE DIEGO

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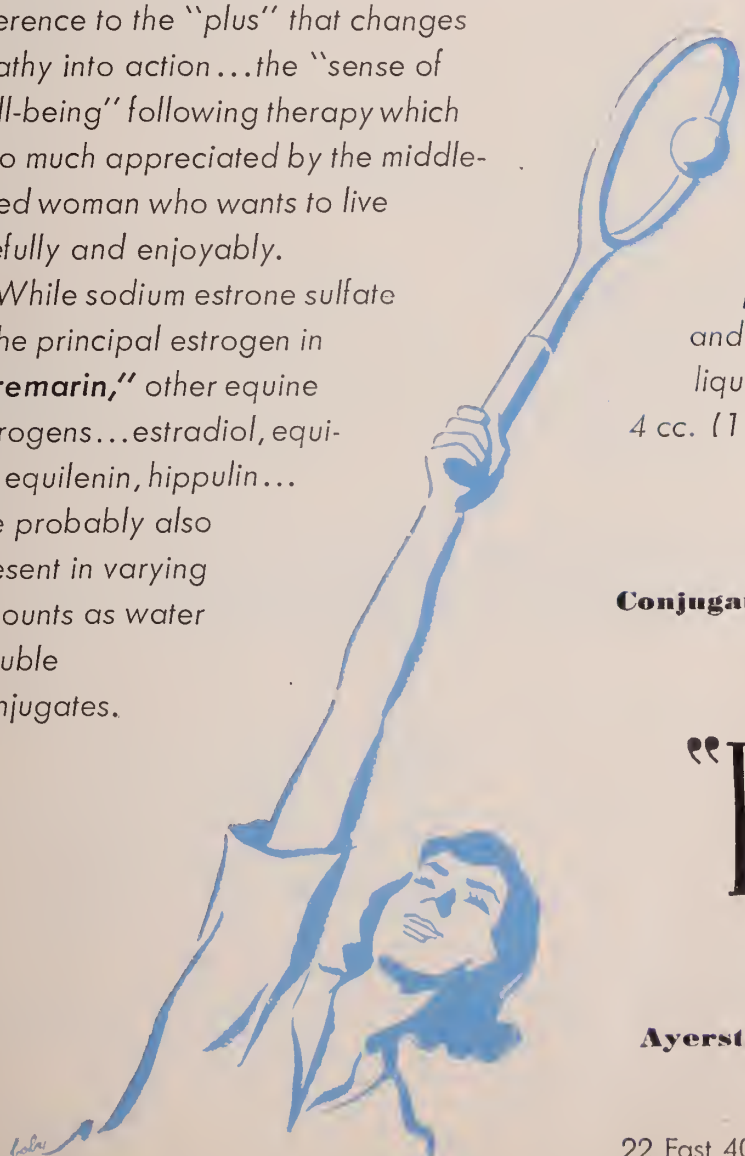
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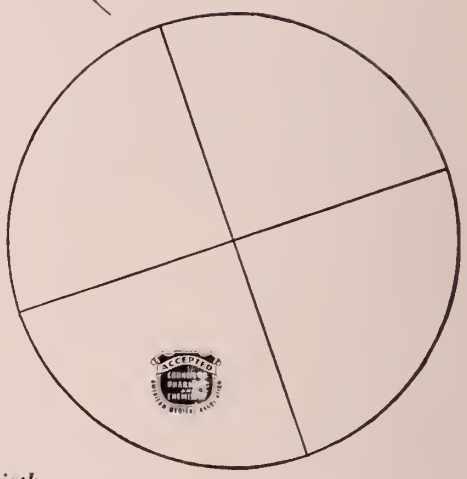
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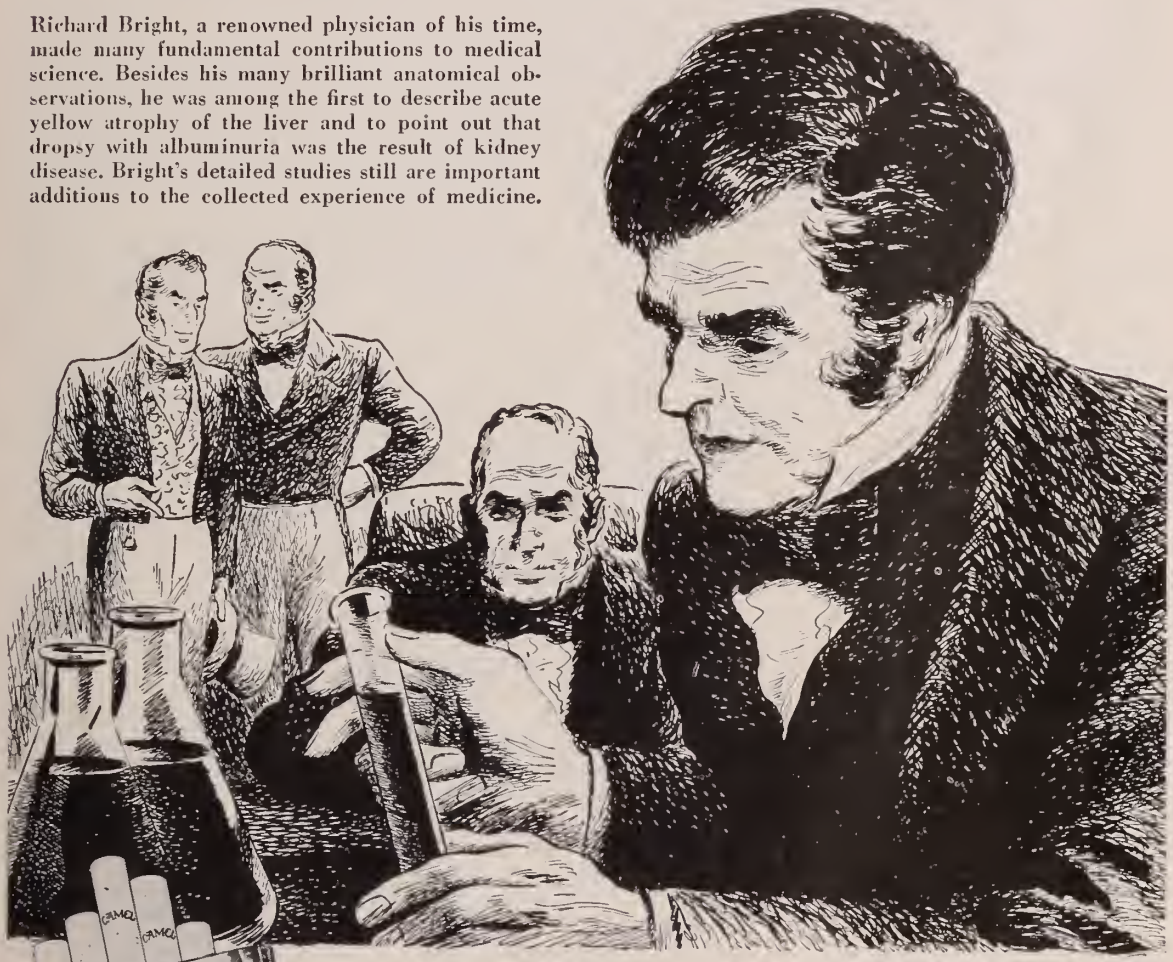


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THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION
PUBLISHED MONTHLY
Volume XXXV Jacksonville, Florida, August, 1948 No. 2

Ophthalmoscopic Observations in Hypertension and Their Import

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JACKSONVILLE

A general knowledge of disease processes and detailed knowledge regarding the ophthalmologic features of disease are of vital importance in ophthalmologic diagnosis in innumerable instances. In hypertension these basic requirements are of particular value and they enable the ophthalmologist to render great assistance to the general practitioner, the internist, the urologist, the obstetrician and the surgeon in the diagnosis and handling of such cases.

The ocular fundus is the screen on which may be observed with the ophthalmoscope the numerous pathologic conditions that may affect the vascular system. The value of ophthalmoscopy is, however, frequently overlooked as a diagnostic and prognostic procedure. The purpose of this paper is to review briefly the findings that may be of help in establishing a diagnosis and making a prognosis from observations of the retinal vascular system. The retinal vessels are microscopic in size, but with the ophthalmoscope they may be readily studied because the media of the eye magnify the image about fifteen times.

CHANGES VISIBLE IN THE OCULAR FUNDUS

Although generalized hypertension may exist for a long time without appreciable evidence appearing in the retinal vessels, it is nevertheless true that a generalized narrowing of the retinal arterioles and localized constriction indicate elevated general blood pressure. At the outset, this localized constriction may arise from "spasm" and may disappear, but its persistence for any length of time points to an organic change indicating that similar changes are probably present in other arteries of the body, with resulting elevation of the general blood pressure.[1]

In many hypertensive states, such as early benign hypertension, malignant hypertension and toxemia of pregnancy, focal constriction, commonly called angiospasm or vasospasm, is the first ophthalmoscopic finding. The mechanism in the development of this focal constriction of the arteriole is as yet undetermined. This early change is manifested by deviation in the normal arteriovenous ratio of 2:3. Constriction may cause the veins to appear two or three times the size of their accompanying arteries, and it becomes impossible to follow the arterioles to the periphery of the fundus; or, a segment of a vessel may appear spastic, making the change in caliber of the narrowed portion easily discernible.

When focal constriction persists, organic changes gradually take place, producing arteriolar sclerosis. The first sign of sclerosis visible ophthalmoscopically is a widening of the light reflex, which may give the vessel a copper wire appearance. With progressive degeneration, proliferation within the retina causes irregularity of the lumen, often called beading. Later, sheathing and narrowing follow, and the vessels may eventually appear as silver wires. Too, the veins become involved in the sclerosing process at their intersection with arteries, and such crossing phenomena as displacement and compression of the soft vein by the sclerosed arteriole are observed. The size relationship between artery and vein becomes an important consideration, for sclerosis tends to cause a narrowing of the arterioles which may alter the normal arteriovenous ratio from 2:3 to 1:3, or more. As further evidence of hypertensive vascular disease, the arterioles may become more tortuous, especially in the macular region, and the entire arterial tree may appear attenuated.[2]

Focal constriction, which may accompany as well as precede sclerosis, is easily differentiated.[3] Uncomplicated, it is accompanied by little loss of transparency, the color of the arterioles is normal (the "reflex stripe" is not exaggerated), and there is no arteriovenous compression. Although the exact time of onset of organic change in a spastic

Read before the Florida Medical Association, Seventy-Fourth Annual Meeting, St. Augustine, April 11-14, 1948.

vessel cannot be accurately determined, some compression of the vein is convincing evidence that arteriolar sclerosis is present. Since hypertension, regardless of its etiology, affects blood vessels in the same way, indications of arteriosclerosis observed ophthalmoscopically point to similar involvement of other organs, it may be assumed, at least to some degree.

In hypertensive retinopathy[2] retinal hemorrhages, cottonwool patches and edema are characteristic. Hemorrhages into the retina, located as they are in the nerve fiber layer, are usually flame-shaped. Frequently they may be observed in close relationship to an arteriole; less often, in round or irregular shape they occur in the deeper layers of the retina. The cottonwool patches, preferably no longer termed exudates, are fluffy, superficially placed, grayish or yellowish white plaques. The powdery flecks, which are the more punctate, more deeply placed, white or glistening spots, are also, and perhaps more appropriately, described as edema residues; they may be isolated or may be grouped at times into clumps resembling plaques or patches. If the radiating nerve fibers in the macular area become separated by edema or occupied by many small, round degenerative lesions, a starlike figure is observed. When the edema residues are grouped appropriately around the fovea, the resulting macular star may be complete or incomplete.

Associated with papilledema are pronounced focal constriction, arteriolar sclerosis in varying degree, hemorrhages, cottonwool patches and edema residues. In its early stages, the presence of this sign is not easily determined. The first indication is disappearance of the physiologic cup, followed by blurring of the margins of the disk. With progression of the process, the disk becomes elevated by a measurable amount, and extension of the edema to the surrounding retina may make observation of the arterioles difficult. The ophthalmoscopic picture of white lines on either side of a vessel arises from filling of the perivascular lymph spaces. The increased pressure in the optic nerve causes the veins to become dilated and tortuous and to appear darker than normal.

CLASSIFICATION

The proper interpretation of retinal lesions in vascular hypertension is dependent on a basic classification. Numerous authors have offered classifications that have received more or less recognition.[3,4,5,6,7] Recently, a committee of the American Ophthalmological Society prepared a report,[8] which has just become available, in which the nomenclature has been standardized and the vascular changes graded in four groups. If physicians of whatever specialty will join the ophthalmologists in familiarizing themselves with this classification and promoting its use, such mutual exploration of the existing knowledge of this key to hypertensive disease and its treatment will be beneficial to practitioners and patients alike, will foster understanding and cooperation between specialists, will avoid confusion and will bring about its general acceptance.

Ten basic principles in the study of the retinal complications of cardiovascular renal disease with hypertension are set forth in this report:

1. Ophthalmoscopically visible arterial vessels of the retina should be designated as arterioles.

2. The three distinct types of alteration occurring in the retinal arterioles in the different phases of hypertensive disease are: (a) generalized narrowing, (which represents probably the generally increased tone of the arteriolar system); (b) sclerosis, or organic thickening of the wall of the arteriole; and (c) focal constriction, or "spasm."

3. In hypertensive or renal disease the term "retinopathy" describes the usually abruptly developing involvement of the retina characterized by serous and hemorrhagic extravasations into and under the retina. The serous extravasation may be represented by diffuse edema, localized "cottonwool" patches, or the more chronic punctate deposits considered to be the late results or residues of edema, including "macular star" formation. When edema of the nerve head is associated with the retinopathy, the terms "neuroretinopathy" or "retinopathy with papilledema" are acceptable.

4. Other distinctive lesions seen in the retina in association with hypertension, arteriolosclerosis and arteriosclerosis, such as venous, arterial and arteriolar closures, and hemorrhagic and edematous lesions originating from organic lesions in the choroidal vessels, should be so designated and not included under the term "hypertensive retinopathy." Designations such as "hemorrhagic infarct" and "ischemic infarct" are advisable in order to distinguish the conditions to which these terms are applied from those known by the term "retinopathy."

5. The component elements of "retinopathy"

are basically identical in all forms of hypertensive and renal disease.

6. Various combinations of the individual lesions listed as being found in the retina and in its vessels make up the ophthalmoscopic pictures characteristic of the several classified types of hypertensive and renal disease.

7. Careful determination of the types of changes visible in the arterioles of the retina is essential for diagnostic and prognostic evaluation of the hypertensive disease.

8. "Grading" of the severity of the arteriolar lesions is of value, especially in determining the advisability of surgical treatment and in evaluating progression of the lesions, but not as essential ordinarily as is proper identification of the types of the lesions.

9. Although constriction of the systemic arterioles in response to some circulating vasopressor substance, or to a central reflex mechanism, may be a factor in initiating the rise of blood pressure, the elevation of the blood pressure in itself is nevertheless the most essential factor in production of the arteriolar and retinal lesions. Practically identical lesions can, therefore, occur both in primary "essential" hypertension and in hypertension secondary to acute or chronic glomerulonephritis, toxemia of pregnancy, unilateral atrophic kidney, pyelonephritis, pituitary basophilism, adrenal tumor, periarteritis nodosa and the like.

10. When focal constriction ("spasm") of the arterioles is uncomplicated, the color of the arterioles is normal (the "reflex stripe" is not exaggerated) and arteriolovenous compression is not present. In many cases of chronic hypertension in which "spasm" is combined with, or superimposed on, arteriolosclerosis, the presence of "spasm," past or present, is indicated by excess constriction of the caliber of the arteriole in its entire course or in focal segments.

In view of objection, particularly among pathologists, to use of the term "exudate" as regards the retina, it is suggested that the more descriptive terms "cottonwool patches" and "powdery flecks" or perhaps preferably "edema residues" supplant this term, but that the term "macular star" be retained. Dropping the terms "arteriosclerotic retinopathy" and "arteriolosclerotic retinopathy" in favor of an accurate differential diagnosis is advised, since the punctate hemorrhages and punctate white areas usually so designated are likely to be end results either of venous occlusion or hypertensive retinopathy; at times they are of diabetic origin. For the diagnosis of retinopathy, the presence of either cottonwool patches or edema or edema residues is requisite.

The following terminology of lesions of retinal vessels associated with vascular hypertension is suggested:

Arterioles
- Generalized narrowing
- Focal constriction or "spasm"
- Generalized sclerosis
- Focal sclerosis
- Sheathing
- Occlusion

Arteries
- Sclerosis of central artery
- Occlusion of central artery

Veins
- Stasis
- Sclerosis
- Sheathing
- Occlusion of a tributary vein
- Occlusion of central vein

Choroidal arteries
- Sclerosis

The terminology of associated retinopathies includes:

Retinopathies
- Retinopathy of acute hypertension
- Retinopathy of chronic progressive hypertension
- Retinopathy of terminal malignant hypertension
- Retinopathy of acute hypertension in glomerulonephritis
- Retinopathy of chronic progressive hypertension in glomerulonephritis
- Retinopathy of terminal malignant hypertension in glomerulonephritis

Suggested grading of lesions of retinal arterioles follows:

Generalized narrowing of arterioles
- Grade 1. Reduction of caliber of arterioles to ¾ average caliber of veins.
- Grade 2. Reduction of caliber of arterioles to ½ average caliber or ⅓ caliber of veins.
- Grade 3. Reduction of caliber of arterioles to ⅓ average caliber or ¼ caliber of veins.
- Grade 4. Arterioles threadlike or invisible.

Focal constriction or focal sclerosis of arterioles
- Grade 1. Localized narrowing to ⅔ caliber of proximal segment of arteriole.

CLASSIFICATION OF VASCULAR HYPERTENSION

TERMINOLOGY	DIAGNOSTIC LESIONS IN RETINA
Neurogenic hypertension	None, even in cases of considerable duration, except perhaps mild generalized narrowing of arterioles.
Acute hypertension ("angiospastic")	No arteriolosclerosis. Generalized narrowing of arterioles. Focal constrictions in arterioles. Edema of retina, cottonwool patches, hemorrhages (usually). Edema of disk (often). May terminate in recovery, in chronic hypertension or in rapidly progressive (fulminating) malignant hypertension.
Chronic nonprogressive ("benign") hypertension	Only mild generalized narrowing of arterioles (grade 1 or 2) if seen in early years. Also mild generalized arteriolosclerosis (grade 1 or 2) if seen after several years' duration of the hypertension. At times ischemic or hemorrhagic infarctions of retina.
Chronic progressive hypertension	Always generalized arteriolosclerosis. Generalized narrowing of arterioles. Focal constrictions in arterioles. At times focal arteriolosclerosis. At times cottonwool patches and hemorrhages in retina.
Terminal malignant hypertension	Always generalized arteriolosclerosis. Always papilledema. Generalized narrowing of arterioles. At times focal arteriolosclerosis. Usually edema of retina, cottonwool patches and hemorrhages. Often residues of edema in form of macular stars or scattered, punctate deposits.

Grade 2. Localized narrowing to ½ caliber of proximal segment of arteriole.

Grade 3. Localized narrowing to ⅓ caliber of proximal segment of arteriole.

Grade 4. Arteriole invisible beyond point of constriction (or in case of focal sclerosis visible only as a thin, fibrous cord).

Generalized sclerosis of arterioles

Grade 1. Brightening or increased luster of the arterioles; mild depression of the veins at the points of arteriolar crossing, with reduction in visibility of those portions of the veins which underlie the crossing arterioles.

Grade 2. Burnished coppery color of the arterioles, with definite depression of underlying veins, widening of the apparent arteriolovenous crossing spaces and almost complete invisibility of those portions of the veins which underlie the crossing arterioles.

Grade 3. Polished silver color of the arterioles, widening of the apparent arteriolovenous crossing spaces with a change in

the course of the veins ("right-angled crossings"), complete invisibility of those portions of the veins which underlie the crossing arterioles and distal dilatation of the veins.

Grade 4. Arterioles visible only as fibrous cords, without blood stream.

In estimating the ratio of arteriole to vein, the decision as to whether the retinal arterioles are pathologically narrowed has to be based, to a certain extent, on the examiner's visual memory of the absolute size of normal arterioles and veins. The ophthalmoscopist becomes so familiar with the normal picture that he is able to compare the appearance of any abnormal condition he encounters with a retained mental impression of the normal as well as if he had the two pictures side by side. In fact, so valuable is this mental impression that it becomes his most useful possession. It is a product of long experience that makes his assistance indispensable to inexperienced observers or other specialists less well trained.

The committee's classification of vascular hypertension is here reproduced in full. Any of the varieties or phases of hypertension included in this classification, except the neurogenic variety, may be primary ("essential") or may be secondary to some demonstrable causative lesion or disease.

DIAGNOSIS AND PROGNOSIS

In their study of the retina in surgical cases of primary hypertension, Wagener, Cusick and Craig[9] concluded that a careful estimate of the grade of the sclerotic changes in the retinal arterioles is of value in determining the suitability of individual patients for surgical treatment in hypertensive disease. In their series of cases the proportion of good results dropped from 40 per cent in those without retinal arteriolosclerosis to 9 per cent in those with pronounced retinal arteriolosclerosis; the percentage of failure rose from 20 per cent in patients without retinal arteriolosclerosis to 82 per cent in those with pronounced retinal arteriolosclerosis.

These authors also noted improvement in the retinal lesions during the immediate postoperative period in 30 per cent of the cases and observed that essentially the same percentage of improvement seemed to be maintained in those cases in which the patient was observed for an appreciable length of time following the operation—34 per cent in their series. They did not observe improvement in the sclerotic or structural lesions in the retinal arterioles. An increase in the grade of arteriolosclerosis was noted in a few cases at varying periods following operation.

In discussing this study, Lillie[9] urged acquaintance with a basic classification of hypertension founded on ophthalmoscopic observations. He stressed the two important facts that patients with the severest type of hypertension—malignant hypertension—gain little or nothing from the sympathetic operation and that those having retinal arteriolar changes without retinopathy obtain the best surgical results.

In response to my inquiry last month at several medical centers, Dr. A. Earl Walker[10] of the Division of Neurological Surgery of The Johns Hopkins Hospital replied that while he does not believe that there is any absolute contraindication for sympathectomy in so far as the fundal findings are concerned, the experience there indicates that patients with severe papilledema and retinal hemorrhages are much more apt to have cerebral complications than those with a fundus more normal in appearance. He added that in a doubtful case from the surgical standpoint, the presence of these pronounced retinal changes has been considered a contraindication to operation.

The decision regarding termination of pregnancy may depend upon ophthalmoscopic observation of retinal changes when hypertension complicates pregnancy. Proper interpretation of these findings often aids in differentiating the type of toxemia present. In pre-eclampsia and eclampsia, according to Hallum,[11] the outstanding change is focal constriction of the arterioles, both localized and generalized, and the degree of constriction is usually in proportion to the severity of the toxemia. With severe focal constriction, retinopathy appears. Such spastic changes occur as a rule in the last trimester of pregnancy, most frequently in primiparas, especially young primiparas. If the focal constriction does not exist long enough to cause organic changes in the walls of the arterioles throughout the body, the blood pressure returns to normal within a few days after delivery and remains so, and the retinal arterioles soon resume their normal caliber. If, however, progress of the disease cannot be controlled by conservative measures, pregnancy should be terminated. Fortunately, ophthalmoscopic examination of the retinal vessels provides an index to the degree of vascular change.[11,12]

In general, the prognosis for a patient with essential hypertension is usually good in the absence of retinopathy. It immediately becomes poor, of course, when hemorrhages, cottonwool patches and powdery flecks are present. These lesions indicate extensive vascular damage even though it may not be apparent in the retinal vessels. The gravest sign is the appearance of papilledema, since it is associated with malignant hypertension.

SUMMARY

Ophthalmoscopic observations in hypertensive disease are described through the progressive stages of focal constriction, arteriolosclerosis and retinopathy. The salient features of a basic classification of these findings and standardization of nomenclature as advocated in a recent report of the committee on Classification of Hypertensive Disease of the Retina of the American Ophthalmological Society are reviewed. It is highly desirable that ophthalmologists and other physicians familiarize themselves with this classification and this terminology sufficiently to make practical use of them and aid in their widespread adoption.

The import of ophthalmoscopic observations in the diagnosis and prognosis of hypertensive states is discussed. Their particular value in indicating the advisability of sympathectomy and of termination of pregnancy is reiterated.

Ophthalmologists who fail to learn properly to classify hypertension from the retinal changes miss perhaps the most interesting phase of medical ophthalmology. The ophthalmoscopist is able to observe these changes in an objective manner, and, as Lillie[9] remarked, when they are classified correctly, one need not be swayed by subjective symptoms. Thus the ophthalmologist thoroughly trained in opthalmoscopy has the opportunity to be of great aid to his colleagues in evaluating their cases of hypertensive disease. The general practitioner, the internist, the obstetrician, the urologist and the neurosurgeon likewise are privileged to avail themselves of the assistance of a competent ophthalmoscopist with the requisite knowledge and experience to classify these cases and give advice regarding their management.

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This is the first of four papers of a symposium on "Hypertension" presented at the second Scientific Assembly at the St. Augustine Convention in April. Subsequent papers are scheduled for publication in early issues of The Journal.

Discussions of the entire symposium will be published at the end of the fourth paper.

Dicumarol in Acute Myocardial Infarction: Its Use in a Small Controlled Series

Henry Fuller, M.D.
LAKELAND

The value of anticoagulants in the treatment of acute myocardial infarction has not been proved incontrovertibly. The rationale for their use is clear. First, they might prevent extension of the clot already formed in the coronary artery. Obviously, this point is difficult of proof. Secondly, they might prevent or lessen thromboembolic complications.

Thromboembolic complications of acute myocardial infarction are exceedingly common. In a recent study of 160 autopsied cases, Hellerstein and Martin[1] found 111 thromboembolic lesions in 73 patients. In over one fourth of these 160 cases, thromboembolic lesions were important as causes of death. When a patient with an acute myocardial infarction is doing badly, it is perhaps most often because the location of the lesion or the size of it is causing congestive heart failure, severe shock, serious arrhythmia or rupture of the myocardium, conditions that might be called primary. Since Blumer[2] and others first directed attention to the importance of embolism as a complication, it has, however, been increasingly evident that many patients with acute myocardial infarction do badly because of thrombi or emboli in locations other than in the coronary arteries. It is worth recalling also that thromboembolic lesions occur almost as frequently in cases without mural thrombi as they do in cases with mural thrombi.[1] There is something about an acute myocardial infarction, in fact there are probably many things about an acute infarction, that dispose the patient to simultaneous thrombosis in other organs. Theoretically, therefore, there is good basis for the use of anticoagulants.

Clinically, there is evidence that anticoagulants are effective. Since dicumarol was first used in 1944 by Nichol and Page,[3] there have been many other favorable reports.[4,5,6,7]

From the Watson Clinic and Morrell Memorial Hospital, Lakeland.
Read before the Florida Medical Association, Seventy-Fourth Annual Meeting, St. Augustine, April 11-14, 1948.

On the other hand, there is some basis for an opposite point of view. Wartman,[8] in 1938, reported on subintimal hemorrhage as a factor in coronary thrombosis. It is true that English and Willius[9] concluded that this is not often important. Nevertheless, there are reports that prothrombinopenia, or an increased tendency to hemorrhage,[10] is a constant finding in early untreated acute myocardial infarction. There have been reported also large series of cases, with a low mortality, in which vitamin K was used in treatment. This is confusing. It is not likely that two methods of treatment so opposite to each other as the use of vitamin K and anticoagulants can both be successful in the treatment of the same disease.

THE PRESENT SERIES

In an attempt to learn something about dicumarol in acute myocardial infarction, I have reviewed the records of all patients with this diagnosis at the Morrell Memorial Hospital in the years 1945, 1946 and 1947, omitting those in whom the diagnosis was not proved, those who died within thirty-six hours (heparin not having been used), and 1 patient who had an acute infarction but who also had blood urea nitrogen levels of 90 and 95 mg. per hundred cubic centimeters on successive days after admission. There remained 69 patients, 34 of whom received dicumarol and 35 of whom did not.

TABLE 1

Cases	40-49 Yrs.	50-59 Yrs.	60-69 Yrs.	70-79 Yrs.	Total
Dicumarol	7	12	7	8	34
Control	5	12	11	7	35
Mortality					
Dicumarol	2	1	0	2	5
Control	0	2	2	6	10

Average Ages	Whole Group	Fatal Cases
Dicumarol	59 Yrs.	57 Yrs.
Control	60 Yrs.	68 Yrs.

The average ages were almost identical. Of the group treated with dicumarol, 5 died; in the control group, 10 died. Twenty-eight days was chosen, arbitrarily, as the duration of the acute attack, and the end results reported here are on that basis.

This group of patients was under the care of several physicians, and it is obvious that dicumarol was not used uniformly. The general plan, however, was to give the drug in sufficient dosage to prolong the prothrombin clotting time to equal or exceed that of a control blood with 12½ per cent prothrombin. The prothrombin clotting time was determined daily, except in rare instances. Controls were run on every new batch of thromboplastin. With the thromboplastin used, the curve was as follows:

TABLE 2

Undiluted plasma	17.5 sec. ± 1.5 sec.
12½% plasma	28.5 sec. ± 2.5 sec.
10% plasma	51.0 sec.

We considered the patients satisfactorily dicumarolized, therefore, if the prothrombin clotting time was thirty-one seconds or more daily. Because we encountered no hemorrhagic complications when the prothrombin clotting time was less than sixty seconds, we did not hesitate to keep it in the forty and fifty second range.

In an attempt to evaluate how well we have kept our patients dicumarolized, we have classed them as satisfactory or unsatisfactory, using the criterion mentioned, as follows:

TABLE 3

	Dicumarol Given Satisfactorily	Dicumarol Given Unsatisfactorily
Whole Group	21 cases	13 cases
Fatal Cases	2	3
Average number of days dicumarol given		19
Greatest number of days dicumarol given		49
Least number of days dicumarol given		5

It is important that in only 21 cases was the drug used satisfactorily, and of the fatal cases in only 2. It is apparent that dicumarol was not used satisfactorily in many cases.

THROMBOEMBOLIC COMPLICATIONS

The clinical recognition of thromboembolic complications of acute myocardial infarction is extremely difficult. In the series of Hines and Hunt,[12] only 2 of 81 pulmonary infarctions proved at autopsy were correctly diagnosed ante mortem. In the series of Hellerstein and Martin,[1] only 5 of 33 were diagnosed correctly. In the present series, the diagnosis of pulmonary embolism or thrombosis was made in 4 cases:

Case 1.—M. G. M., a 59 year old man, had a proved anterior infarction on February 20 and five days later had sudden onset of dyspnea with bloody sputum, pain and tenderness in the left side of the chest, and elevation of temperature lasting six days. Roentgen examination of the chest showed an exudate at the left base. He improved greatly. Dicumarol was not used.

Case 2.—T. B. H., a 53 year old man, had an anterior myocardial infarction on August 24 and thirteen days later had sudden pain in the left side of the chest, worse on respiration, with elevation of temperature lasting five days. Subsequent electrocardiograms did not show further myocardial involvement. Dicumarol was not used.

Case 3.—M. M., a 65 year old man, had an attack of pain on October 5 and was admitted to the hospital on October 10 with a typical acute anterior infarction. Fourteen days after admission, he had an acute pulmonary embolism, so diagnosed because of the sudden onset of severe pain, pleural friction rub over the anterior wall of the chest on the left side, and elevation of temperature. Dicumarol was begun on October 24, nineteen days after the myocardial infarction took place. He was critically ill for five days, but recovered.

Case 4.—F. C., a 56 year old man, was admitted to the hospital on June 12, seven days after what was probably his second (or more) myocardial infarction. He improved until June 15, or ten days after the onset of this attack, when there developed pain in the chest on the right side, fever and a pleural friction rub, and he became seriously ill again. Further electrocardiograms showed no new infarcts. Dicumarol was begun then, and six weeks later, he was discharged much improved, up and walking.

In all four cases, dicumarol either was not used at all, or was not begun until after the complications arose.

In this series, there were 2 cases of cerebral thrombosis or embolism:

Case 5.—W. G., a 71 year old man, was admitted to the hospital two days after the onset of an attack shown to be an acute anterior infarction. Eighteen days later, while he was doing well, there suddenly developed paralysis of the right forearm, and he complained of blurred vision. This condition lasted one day, then gradually improved. Four days later, after being apparently much better, the patient died suddenly. He had not had dicumarol.

Case 6.—G. V., a 65 year old woman without any previous history of a mental disorder, was admitted on May 22, 1946 with an acute posterior infarction of two days' duration. Delirium developed and persisted. There was no cardiac congestive failure, nor was there evidence of renal failure. The patient had to be committed to an institution because of the psychosis.

In no case in which dicumarol was commenced soon after the attack and given satisfactorily was there any incident that the visiting physician or that we, reviewing the records, could call a thromboembolic complication, except in the fatal cases.

In this series, in 7 cases death occurred suddenly when the patient appeared to be doing well. These deaths occurred from the ninth to the twenty-second day. They were instantaneous. "The patient was being fed and suddenly died," for example, is a typical note. Without autopsies, it cannot be proved what the cause of death was. It is extremely probable that in most cases, however, it was either a massive pulmonary embolism or another coronary thrombosis. Both should be considered complications of the original coronary thrombosis when they occur a few days after the original attack.

Of these 7 cases, 4 occurred in the control group and 3 in the group treated with dicumarol; but of these 3, dicumarol had not been given satisfactorily in 2 and probably had not in the third.

Case 7.—J. G., a 50 year old man, was admitted on Nov. 11, 1947 with an anterolateral infarction, his second attack, and he improved after three days in an oxygen tent. He seemed to be doing well, but died suddenly sixteen days after the onset of the attack. Prothrombin clotting time was only twenty seconds the day before death.

Case 8.—S. H., a 42 year old woman who had had pronounced hypertension for sixteen years, was admitted five days after an acute anterior infarction. Dicumarol was begun at once. It was given only three days and was then discontinued. The prothrombin clotting time the third day was eighty-six seconds. No determinations were made afterward. Apparently she improved, then died suddenly.

Case 9.—H. D., a 49 year old man who had had a previous coronary thrombosis four years before, was admitted with an acute anterior infarction and died suddenly twelve days later. On the day of death, the prothrombin clotting time was twenty-six seconds. He had seemed to do well up until death.

The other two patients in the group receiving dicumarol who died, both died in cardiac congestive failure.

TABLE 4

(A) Fatal Group	Control	Dicumarol
Died suddenly from 9 to 22 days	4	3*
Died with cardiac congestive failure	6	2

*Prothrombin clotting time not satisfactory in 2 cases.

Thromboembolic Complications		
(B) Surviving Group	Control	Dicumarol
Pulmonary infarction	2	2**
Cerebral vascular occlusion	2	0

**Before dicumarol was begun.

CONCLUSION

In such a small series of cases as this, without autopsies, in a disease with as many variables as acute myocardial infarction, it is not proper to draw any conclusions. It is suggestive, however, that in the group receiving dicumarol, (1) the mortality was lower and (2) thromboembolic complications were less.

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I wish to express my thanks to the following physicians for permission to use their records in this series: Drs. Jere W. Annis, Joe M. Bosworth, Jr., S. Allen Clark, Samuel J. Clark, Everett S. King, John G. Lester, William P. Logan, Geo. C. Overstreet, T. Hugh Roberts, Raleigh R. Sullivan, John W. Vaughn, James R. West, Edgar Watson and John F. Wilson, Jr. Box 1021.

DISCUSSION

Dr. E. Sterling Nichol, Miami: I should like to congratulate Dr. Fuller for his concise presentation and for having an adequate control group. The rationale of the use of anticoagulants in acute myocardial infarction needs emphasis. Thromboembolic complications occur in the course of myocardial infarction in 20 per cent of cases. Extension of the original thrombosis is often overlooked, and secondary occlusion occurs probably in 10 or 12 per cent of cases in any large series. Pulmonary embolism develops during the healing stage because of thrombophlebitis in the legs or pelvis, but may arise from mural thrombi of the right ventricle.

The mortality of 15 per cent encountered by the author is in line with larger groups reported; if the reported cases in the literature are added to those available for analysis not yet reported, a mortality of 14 per cent occurred in 425 cases, in contrast to 28 per cent in 2,189 cases not treated reported since 1940. In the American Heart Association Cooperative Study, the figures available indicate a mortality of 15 per cent in 432 treated cases compared to 24 per cent in 368 control cases.

As the only complication of anticoagulant therapy is bleeding, it is of interest that of about 7,000 cases of all types reported treated with dicumarol bleeding occurred in 4 per cent. There have been 7 or 8 deaths reported from uncontrollable hemorrhage. In my own group of cases of acute myocardial infarction there was an episode

of bleeding in about 8 per cent, more than half being gross hematuria. In no case was there any difficulty in controlling hemorrhage.

Rigid laboratory control is essential in the use of anticoagulants. If heparin is used, a Lee-White clotting time should be determined every twelve hours, and it should be kept in mind that the prothrombin time is affected by heparin also; so the prothrombin time should be determined at least four hours after the heparin effect. Use of dicumarol necessitates daily prothrombin tests at first, the aim being to keep the prothrombin time in seconds at twice the normal average prothrombin time as found by the same method by the same laboratory. This will usually be in an effective yet safe range and in terms of percentage of prothrombin activity will be between 20 and 30 per cent. If percentage reports are given by the laboratory, the computation should be by comparison with a dilution curve, as a simple ratio is meaningless, a fact unfortunately overlooked by the physician as well as the laboratory.

DR. W. DEAN STEWARD, Orlando: I have enjoyed Dr. Fuller's paper and Dr. Nichol's discussion. This paper is an example of the type of study that can be carried out in a small hospital, and when many such studies, with controls, are grouped together, much information can be obtained for or against a specific point. My experience has been in line with that presented by Dr. Fuller. I believe that the use of anticoagulants is of value in myocardial infarctions. It might be worth mentioning that their use is especially indicated in patients receiving penicillin or digitalis because these substances affect the viscosity and clotting time of the blood.

One other point Dr. Nichol brought out was that those patients seen late, and particularly those who have already had embolic phenomena, should receive heparin in addition to dicumarol during the first thirty-six to forty-eight hours.

Again I want to express my appreciation for the opportunity of discussing this paper.

DR. FULLER, concluding: I want to thank Dr. Nichol and Dr. Steward for their discussion and to say two things. First, all of us have probably thought about it, but it is important to remember that thrombosis, including mural thrombosis, phlebitis of the legs, mesenteric thrombosis and cerebral vascular occlusion, occurs more often in this disease than in most other diseases because of the slowing down of the circulation, drop in blood pressure and hemoconcentration. This is the reason, of course, that anticoagulants certainly would seem to be useful. Just as Dr. Nichol said, it remains to be seen if they actually will. Second, our prothrombin clotting times were slightly different from others reported. Accordingly, therefore, we wrote to the company from which the thromboplastin was obtained, and they replied that our prothrombin clotting times were within their accepted values.

Health Center Buildings

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When it is recalled that the health department now exerts and seems likely to continue to exert an influence for good over the lives of the people comparable to that of the church, the school or the police department, one has every reason to expect that it will be given adequate facilities with which to work. These include personnel sufficient in numbers and well trained for their respective tasks, equipment of good quality and health center buildings suited to this purpose.

The local health department as a separate governmental agency is, however, of recent origin. Charleston, S. C., is believed to have organized the first bona fide urban health department in the United States about one hundred and fifty years ago. Several areas dispute the honor of being the first to set up an organization to cover a rural area, staffed by full time employees and with responsibilities for conservation and promotion of the health of all the people. Suffice it to point out that no county health department has been in existence for more than forty years, and less than a third of the more than sixteen hundred local health departments now in existence were organized before 1930. The first county health department in Florida is said to have been that in Taylor County, which was organized in 1930, but service was interrupted in 1933. The one in Leon County, organized in 1931, has had no interruption, and now all except five counties are covered by full time county health service. In view of the newness of this service, health officers should not, therefore, be dismayed on learning that only three of Florida's thirty-nine local health units are properly housed to do their best work.

DEMONSTRATION PROJECTS

Several of the larger philanthropies in this country early recognized the health department or unit as an agency with enormous potentialities for sustained prevention of illness and the promotion of health. Among those which have made noteworthy contributions in demonstrating the effectiveness of the local health unit should be

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Read before the Florida Health Officers' Society, Third Annual Meeting, St. Augustine, April 11, 1948.

mentioned the Rockefeller Foundation, the Milbank Fund, the Kellogg Foundation and the Commonwealth Fund. My experience in public health has been gained in large measure from intimate association with eleven of the fourteen local health demonstrations to which the Commonwealth Fund has made a financial contribution, and the opinions expressed in this paper are based on the housing needs which became evident in these local health departments* located in Massachusetts, Mississippi, Oklahoma and Tennessee.

The last of these demonstrations,** located in Kay County, Okla., is being concluded June 30, and with the exception of the two located in Massachusetts, all have been continued with their whole financial support coming from local and state funds. At the conclusion of the demonstration in nine of these areas*** the Fund made an appropriation for construction of a building to house the health department on a site provided locally. In each instance the completed building was donated to the community for the exclusive use of the health department.

CONTROL OF BUILDING

To give added assurance that the building would not be turned to other purposes, a board of trustees composed usually of seven persons was set up to receive and hold the lot and building for the community. This board is usually made up of three city or county officials, who automatically become trustees for the term of office to which they are elected, and a majority of nonofficial citizens of the county who have shown interest in promoting the public health. On recommendation of the local health officer the nonofficial members of the board are appointed by the state health officer for overlapping terms.

The local health officer is an ex-officio member of the board without voting power. As a rule the board appoints him secretary, and the by-laws usually provide also that he shall act as executive agent for the board to supervise construction of the building, direct its daily operation, make necessary repairs and renovations, and report periodically to the holding group on the condition of the building and its use. In at least one instance the board of trustees has found it advantageous to become incorporated under the laws of the state.

Whatever the method of control, it should be one which removes the building and the space occupied by the staff of the health department from the vagaries of political manipulation and assures a degree of permanence which permits installation of expensive equipment, like the x-ray and the dental chair, without the prospect of their having to be moved.

FINANCING

The cost of all types of construction seems exorbitant these days. Space which cost the Commonwealth Fund 33 cents per cubic foot to construct in 1936 can hardly be duplicated now for $1.40 per cubic foot. Nevertheless, a fair estimate of the cost of space to house a health department staff adequately can be arrived at by the formula: construction cost equals twice the annual cost of the service to be housed. For example, if the health department plans to render only a preventive and educational service with a $50,000 annual budget, fairly adequate space and equipment for such a service can be provided by a capital outlay of $100,000. It must be borne in mind, however, that it is relatively more expensive to provide adequate housing for a small staff than for a larger one. Experience over the country indicates that a population unit of 50,000 is about the smallest which can expect to receive adequate health service for an annual cost of $1.75 per capita. Also, a population unit of this size is approximately the smallest which warrants the outlay required for construction of complete facilities to house a health department.

Actually any community in need of a health center building should build now. In the first place, there is but slight prospect that building costs will become materially lower. In the second place, the availability of federal funds under the Hill-Burton act will take care of one third of the overall cost of the site and construction and equipment of the building. The Florida State Improvement Commission has been designated as the state agency to administer these funds and in collaboration with the state health department has determined the health center needs for each county in the state. All of you here are doubtless familiar with the results of this survey.

*Southern Berkshire and Nashoba districts in Massachusetts; Sullivan, Sumner, Rutherford and Gibson counties in Tennessee; Pike, Lauderdale and Jones counties in Mississippi; and Seminole and Kay counties in Oklahoma.

**The Fund believes that no additional local health demonstrations or buildings with financial support from the Fund are indicated and will in the future direct its resources into other channels.

***No buildings were constructed in the Southern Berkshire District of Massachusetts and in Kay County, Okla.

DESIRABLE BUILDING FEATURES

SPACE REQUIREMENTS.—Each type of personnel differs in its spatial and equipment requirements. At a minimum, separate office space should be provided for each of the four essential members of the staff, namely, the health officer, nurse, sanitarian and clerk; in addition, a clinic, a waiting room, a heater room, toilets and corridors are required.

The optimum space to house the staff required for a population of 50,000 should include provision for two medical officers, the director and his assistant; ten nurses, including the director and nine staff nurses; two sanitarians; four clerks, one of whom would be an administrative assistant or chief clerk trained in elementary statistical technics; a dentist; a health educator; a laboratory and x-ray technician, and a janitor. We should plan for eleven rooms therefore for administration including laboratory and x-ray: health officer, 120 square feet; assistant health officer, 100 square feet; director of nursing, 100 square feet; 9 staff nurses, 150 square feet; 2 sanitarians, 150 square feet; administrative assistant, 100 square feet; 3 clerks, 180 square feet; 1 dentist, 100 square feet; health educator, 100 square feet; laboratory, 240 square feet; x-ray, including film storage, 300 square feet.

Diagnostic and preventive treatment service to be given by a staff of this size should include also a utility room, 150 square feet; and three examination-treatment rooms with built-in dressing nooks, 100 square feet each. A combination waiting room, 200 square feet, and library, 200 square feet, separated by folding doors, can be used as one room for larger meetings. The furnace, designed to burn gas or oil, to provide heat and hot water, will occupy at least 80 square feet, and if air conditioning is required, also an additional space, 185 square feet will be required. The toilets and janitor's supply room will take up another 150 square feet of floor space, corridors will require about 700 square feet, and about 350 square feet should be allowed for various types of other storage. The gross area of such a building, built one story high without a basement, approximates 4,900 square feet and has a cubage of about 67,000 cubic feet.

LOCATION AND SITE.—It is assumed that the population will be so distributed that the whole staff can work conveniently out of one office and that racial considerations do not require separate facilities for white persons and Negroes. Additional waiting room space, toilets and perhaps also another treatment room may be required for the Negroes. If the staff is to be augmented periodically by persons sent to the area for training, additional space should be provided for their accommodation when the health department building is planned.

There are obvious advantages in administration, staff supervision and training, record keeping and other duties when the whole staff can work out of a central office, using small suboffices for clinics which cannot be held conveniently at the central office. It occasionally happens that for reasons of policy or difficulties in transportation, the staff must be divided into two or more groups. One is then forced to a difficult decision, and all too often neither portion of the staff is adequately housed.

In general, the offices of the health department should be located at the center of population and preferably in the largest urban area to be served, even though this may not be the seat of local government.

The site for the location of the building should be selected with great care. It should be adequate in area to accommodate the building to be erected on it and also provide off-street parking for all staff cars. The character of the site selected will likely determine whether a basement will be included, but unless it is readily accessible, money spent on construction of a basement will be wasted for it will get little use. A one story building such as that described should be placed on a lot with an area of at least 15,000 square feet. The site should be readily accessible to public transportation facilities, and to water, electric power, sewers, telephone and telegraph. Preferably it should be located on a corner lot on two paved streets, at least one of which may be used for parking the cars of visitors to the health department. There are obvious advantages to be had from a site immediately adjacent to a good general hospital, with the facilities of each available to the other. Such an arrangement may avoid duplication of expensive equipment and make possible employment of better trained technical service than either could afford alone. Of even greater importance perhaps is the advantage to each facility in being able to consult with the other over problems of mutual interest. Many op-

portunities to correct individual problems are lost when the health department and hospital are not conveniently near.

Preferably, both the health department and hospital should be located in a noncommercial, restricted area and yet where they are readily accessible. Limited space may necessitate constructing the health center building with a basement, or even a second floor above the ground, both of which are less expensive types of construction than a one story construction. No one likes to work in a basement. It is likely to be damp in wet weather, difficult to heat and not satisfactory for storage. In areas, however, where dampness is not a factor, the furnace may be located in a basement and if access is easy, a meeting room may be placed in a basement.

Type of Construction.—We are of the opinion that the services of a competent architect are well worth the cost in construction of this kind. He should be asked to design a building which combines utility, pleasing inward and outward appearance, fire resistance and low maintenance cost.

Among the specifications adopted by the Fund's architect to meet these requirements were the following:

Foundations.—The foundations were carried at least 2 feet below the existing surface and were of reinforced concrete to prevent cracking.

Floors.—For the one story buildings without basement, integral finish and a 4 inch thick concrete slab, reinforced with mesh and resting on a minimum thickness of 1 foot of gravel were required. The flooring was of asphalt tile with asphalt tile base throughout except in the heater, air conditioning and toilet rooms. Tile floors and base were specified for the toilet rooms, and other space where no asphalt tile was called for had cement floor and base.

The earlier buildings had battleship linoleum laid over wood sub-floors in the place of asphalt tile. The asphalt tile is perhaps a little more costly to install but is more fire-resisting, and the upkeep is less expensive than the linoleum over wood.

Building Frame.—Wood studs, ceiling and roof beams were used, except around the heater rooms, the walls of which were of terra cotta tile.

Exterior Walls.—Brick veneer walls reinforced horizontally with chicken wire mesh to prevent cracking were specified.

Windows.—The windows were of wood, double-hung.

Roof.—Tile was specified on all buildings because it is fire-resisting and the maintenance is low. It has the disadvantage of being expensive to install.

Interior Finish of Walls.—Plaster on metal lath, painted with two coats of oil paint, was used.

Ceiling. — Hung metal lath and plaster, painted with two coats of oil paint, were used.

Flashing.—Copper flashing was specified.

Interior Trim.—Birch, stained and varnished, was chosen.

Heating.—Gas or oil was preferred, with forced hot water system and radiators under the windows. In our experience hot air with automatically controlled distribution has not proved satisfactory for the reason that the controls are too complicated for the service people available in rural areas.

Plumbing.—Hot and cold water and drains were provided for all fixtures when required. A drinking fountain with foot control is desirable as are hose bibs for lawn sprinking.

Electric Fixtures.—Fluorescent lighting was specified in the recent buildings, as was adequate current to operate a 150 milliampere x-ray machine. Also, conduits for telephones and a complete buzzer system should be specified. At least one plug-in electric outlet should be provided in each room in addition to the standard fixtures.

Guarantee.—The contractor should be required to guarantee all material for a period of two years after completion of the building.

Grounds.—Naturally advantageous features of the building site should be carefully preserved. It may take several years to replace a tree which with a little care could have been saved. If the lawn requires grading and there is any top soil available, this should be saved to cover the new grade. In several instances the local health officer has been able to enlist the interest of the local garden club to assist in the landscaping. Provision for off-street parking of staff cars should be included as a part of the building plan.

Equipment.—I shall not attempt to review the equipment needs in detail, but will mention only a few items which should receive particular attention.

A waist-high counter across the front of the clerk's offices has advantages over a rail or grill

between the clerk and the corridor. Closets in each room save many steps and promote efficiency. All telephones should pass through a switchboard under the control of the clerk-receptionist so that she may dispose of incoming calls as required. Similarly, the intercommunicating system should be controlled by the clerk-receptionist.

Every health center building should have a bulletin board for the staff and another in each waiting room, but notices should not be posted unless they are pertinent and should be removed promptly when they are no longer applicable. The health educator, if there is one, and the head nurse should share responsibility for keeping readily available in the waiting rooms and on suitable display racks pertinent and timely educational material for the public. The health officer should take primary responsibility for making available in the library magazines and timely books for use of the staff and other professional groups invited to use this facility.

The major pieces of technical equipment which should be available either in the building or conveniently nearby are the x-ray, dental chair with accessories, refrigerator, autoclave, sterilizer and other laboratory apparatus which the situation may demand. Depending on the location and type of program, the cost of equipment and furniture including all of the items listed may run to approximately $20,000.

CONCLUSION

It is easy to forget the public health endeavor at its best embraces the principles of sanitation, preventive medicine, nursing care, statistical analysis, dissemination of health knowledge to all the people and application of these principles by a group of specially trained workers who have learned to coordinate their efforts. Teamwork of this kind is becoming increasingly available to many counties, but it can rarely be found where the health department is poorly and inadequately housed and the workers are ashamed of their surroundings. The desirable features to be considered in planning health center buildings are reviewed.

41 East Fifty-Seventh Street.

Liver Function Tests

JOHN P. ROWELL, M.D.
ST. PETERSBURG

Liver function has been the subject of intensive study during recent years. The epidemics of infectious hepatitis during the last war afforded means of evaluating tests for impaired liver function and were an impetus towards simpler and more specific tests of liver function. The purpose of this paper is to select from the twenty odd tests those few which physicians should use with the laboratory facilities available and to group the tests according to the problem under study.

The accurate estimation of the functional capacity of the liver is difficult for several reasons. First, there is its tremendous reserve capacity. It has been estimated that only 15 per cent of the tissue of the liver is necessary for the performance of most of its functions. The second consideration is its remarkable regenerative capacity, and the third is its many functions in the body. The liver acts as the body commissary, maintaining the level of glucose in the blood, synthesizing amino acids and building proteins. It has excretory, secretory, detoxifying and other metabolic functions. Thus, no single test can give an estimate of the total efficiency of this organ, and it is necessary to use combinations of tests to evaluate liver function. Likewise, it is necessary to repeat the tests at short intervals to keep informed of the changing status of liver function.

The liver function tests are grouped according to the clinical information wanted:

1. Sensitive tests for detection of minimal impairment.
2. Tests for chronic hepatitis and cirrhosis.
3. Tests for maximal impairment.
4. Tests for acute hepatitis.
5. Tests for the differential diagnosis of jaundice.

Read before the Pinellas County Medical Society, April 1, 1948.

SENSITIVE TESTS

These are used to detect early impairment of liver function and may be used as screening tests in cases of suspected damage of the liver. One must keep in mind that as the sensitivity of a test increases the chances of a positive reaction due to factors other than disease of the liver increase. These factors are chiefly a severe anemia, a toxemia or chronic passive congestion.

Cephalin-Cholesterol Flocculation Test.—This is a simple test and a sensitive index of parenchymal hepatic involvement. The test is done by adding a small amount of serum and saline to a cephalin-cholesterol suspension and reading the degree of flocculation in twenty-four and forty-eight hours. A reading of 2, 3 or 4 plus indicates definite parenchymal damage. Although usually there is no flocculation with normal serum, a reading of plus-minus in twenty-four hours and 1 plus in forty-eight hours is still considered normal.

In interpreting the cephalin flocculation test, it must be kept in mind that this is only indirectly a liver function test and actually depends upon changes in the globulin fraction of the serum proteins. In other diseases associated with hyperglobulinemia the results of this test may, therefore, be strongly positive. Important among these are lymphogranuloma inguinale, rheumatoid arthritis, subacute bacterial endocarditis and certain neoplastic diseases such as multiple myeloma.

Bromsulfalein Test.—This is called an excretory loading test and is a true test of liver function. The best modification involves the intravenous injection of 5 mg. of the dye per kilogram of body weight and obtaining blood specimens in thirty and forty-five minutes. The results are reported in percentage of the dye remaining in the blood. Any dye remaining after forty-five minutes signifies hepatic impairment. The liver usually clears the blood of the dye in thirty minutes, but up to 10 per cent is considered normal. This test, often called the BSP test, is sensitive; yet with these standards, it very seldom gives false positives. One drawback is that the results are read by color comparison on the serum, and in the presence of jaundice the results are approximate. Consequently, this test should never be used in a severely jaundiced patient.

Thymol Turbidity Test.—This test is read in thirty minutes and is reported in units. Normal serums average 0 to 4 units. In disease of the liver, particularly infectious hepatitis, the readings will be from 10 to 40 units. This test is easier and quicker than the cephalin flocculation test, but is not as sensitive. Also there is no correlation between the height of the reading and the severity of hepatic damage.

TESTS FOR CHRONIC HEPATITIS AND CIRRHOSIS

In this group, the objective is the determination of the severity of the damage to the liver, and the follow-up of the disease.

Icterus Index.—This is by far the most widely used test in disease of the liver. Four to 6 units is generally considered normal, and between 6 and 15 units indicates latent jaundice.

Serum Bilirubin or Quantitative van den Bergh Test.—The result in this test is reported in milligrams, the upper limit of normal being 1 mg. The information obtained is similar to that of the icterus index. It is more accurate, but is technically difficult and more expensive to the patient. The ratio of bilirubin to icterus index is about 1 to 10 at the lower levels and about 1 to 5 in severe jaundice. In parenchymal jaundice, without obstruction, repeated bilirubin determinations give a rough estimate of liver function.

Bromsulfalein Test.—This test is useful in estimating the severity of chronic hepatitis or cirrhosis. It is an excretory test, and if the liver is unable to excrete bilirubin, or in other words if jaundice is present, little information can be obtained from studying bromsulfalein excretion. In the presence of more than slight degrees of icterus, the bromsulfalein test may give deceptively high readings.

Cephalin Flocculation Test.—This is a very useful test in evaluating damage to the liver and determining the prognosis. If the reaction stays persistently 4 plus even with apparent recovery of liver function, it indicates a bad prognosis.

Galactose Tolerance Test.—Forty grams of galactose in 500 cc. of water is given the fasting patient, and the urine is collected for five hours. A normal liver will convert this to glycogen, and not more than 2.5 Gm. of galactose will be excreted. A finding of over 3 Gm. of galactose in the urine is significant. This test is not very sensitive, but will give additional information in obvious hepatic impairment.

Intravenous Hippuric Acid Test.—This is a test of the synthesizing ability of the liver. A 20 cc. solution containing 1.7 Gm. of sodium benzoate is injected intravenously, and the urine is collected after one hour. In the liver the sodium benzoate is combined with glycine to produce hippuric acid, and at least .8 Gm. should be ex-

creted in the one hour urine. This is a good test for efficiency of this organ, but the laboratory estimation of the hippuric acid is technically difficult. Likewise, normal kidney function is a prerequisite for a dependable result.

TESTS FOR MAXIMAL IMPAIRMENT

If the aforementioned tests show severe hepatic damage, further information regarding the severity may be obtained from a serum albumin determination and the albumin-globulin ratio and from the prothrombin time. Normal serum albumin is about 5 Gm. per hundred cubic centimeters, and a figure below 4 Gm. is indicative of hepatic disease. If the albumin falls below the globulin, particularly if it is below 2.5 Gm., there is severe damage, usually a long-standing cirrhosis.

An elevated prothrombin time may be due to deficient absorption of vitamin K from the intestine owing to biliary obstruction, or it may be due to inability of the liver to form prothrombin. If 10 mg. of vitamin K is injected, the prothrombin time should fall to normal in less than twenty-four hours. Failure to do so indicates severe hepatic damage and contraindicates any surgery.

TESTS FOR INFECTIOUS HEPATITIS

In this distinctive condition among diseases of the liver, the icterus index, or serum bilirubin, the cephalin flocculation and the thymol turbidity tests are the useful ones. The cephalin flocculation reaction tends to occur sooner in the disease than the thymol turbidity reaction and gives a more accurate appraisal of the severity of the hepatitis. The thymol turbidity test is, however, the best one to determine when the hepatitis has completely subsided. It will give positive results as long as there is any latent infection and should be used to determine when the patient should be allowed full activity.

TESTS FOR THE DIFFERENTIAL DIAGNOSIS OF JAUNDICE

Of primary importance is the differentiation between obstructive and hepatogenous jaundice. The other type of jaundice, hemolytic jaundice, is not common and a combination of certain laboratory findings establishes the diagnosis. Thus in hemolytic jaundice, the icterus index is below 50, and there occur normal bile pigment in the stools, an absence of bilirubin in the urine, an increase in urinary urobilinogen, an indirect van den Bergh reaction, an increased reticulocyte count in the blood and an enlarged spleen.

The Qualitative van den Bergh Test.—This is a useful test early after the onset of jaundice. The indirect reaction is due to blood pigment called hemobilirubin before it passes through the liver cells and is positive in hemolytic jaundice. Likewise, early after the onset of hepatogenous jaundice, the van den Bergh reaction is indirect although soon injury to liver cells causes the more dialyzable cholebilirubin to get into the blood, producing a biphasic reaction. Early after obstruction the reaction is purely direct, but soon cloudy swelling of the liver cells causes an increase in hemobilirubin, resulting again in a biphasic reaction.

Quantitative Urinary Urobilinogen Test.—This simple test serves a twofold function. Persistent absence of this pigment from the urine indicates obstructive jaundice particularly if associated with acholic stools. Elevations above the normal range occur when there is disease of the parenchyma of the liver.

The Intravenous Hippuric Acid Test.—In obstructive jaundice, normal excretion of .8 Gm. or over is expected. A reading below .7 Gm. suggests hepatogenous jaundice except after prolonged obstruction when the excretion falls.

Galactose Tolerance Test.—As this is a less sensitive test, obstruction produces no change, and the excretion of galactose will not be over 3 Gm. If 4 Gm. or over is excreted, it indicates hepatogenous jaundice.

Cephalin Flocculation Test.—In obstruction, the reading is negative or 1 plus while in hepatogenous jaundice, the result will be 2 plus or more.

Serum Alkaline Phosphatase Test.—In obstructive jaundice, there is an elevation of the serum alkaline phosphatase. The normal in adults is about 4 Bodansky units; over 10 units indicates obstruction. Dr. Franklin W. White of Harvard University stated: "The diagnosis of common duct obstruction is highly improbable if the serum phosphatase is below 10 units and the cephalin test is strongly positive, and icteric patients should be subjected to exploratory operation if the serum phosphatase is over 10 units and the cephalin test is negative."

SUMMARY

An attempt is made to group the various liver function tests according to the problem under study. It is believed that a better understanding of the newer liver function tests will result in the earlier recognition of hepatic insufficiency. It will result in the more careful follow-up of infectious hepatitis. Intelligent use of the right tests will permit earlier and more accurate differentiation between obstructive and hepatogenous jaundice.

506 Florida Power Building.

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PHYSICIANS AND THE DRAFT

The recent action of the Council on National Emergency Medical Service in opposing the drafting of physicians should meet with the approval of all fair-thinking people.

Physicians, taken as a whole, certainly do not wish to shirk any duty. On a voluntary basis they have made an important contribution and have accomplished much in the past. Hence, legislation which would single them out as a separate group from their fellow citizens for registration, draft and induction into the armed services would appear to be unfair and decidedly undemocratic.

Service rendered by the physician in a national emergency, however, is of great importance, and the prospective need for that service now is real. Recognizing that need, the Council on National Emergency Medical Service recommended, even urged, immediate establishment of a civilian medical board which would be responsible for the policies and programs required for the medical, health and sanitary services of the civilian population, industry, agriculture and the armed forces in time of emergency.

The council further recommended, in time of national emergency, the establishment of a priority system for calling up civilian medical personnel, as follows:

1. Those recent graduates who were enroled in A. S. T. P. or V-12 programs who have not completed their obligated tour of duty as a medical officer and all others who were deferred by selective service to continue their medical education.

2. Other physicians who did not serve in World War II.

3. Those physicians who served the least in World War II.

The council further urged that all state and local medical associations exert every effort to establish such a civilian medical board on the highest level of the national government.

Recognition of problems and adequate discharge of duty on a voluntary basis are one of the aims of most members of the medical profession. Full cooperation with the Council on National Emergency Medical Service along the lines suggested appears therefore to be in order.

WHAT IS THE BROOKINGS REPORT?

To the annals of medicine there has recently been added a history-making document entitled "The Issue of Compulsory Health Insurance." So important is this scientific report on a subject vital both to the medical profession and to the nation that every physician should obtain it, study it and keep it handy for reference. Nor should he fail to direct the attention of the laity at every opportunity to its conclusions and wise counsel.

In May 1947 Senator H. Alexander Smith, chairman of the Subcommittee on Health of the Senate Committee on Labor and Public Welfare, invited the Brookings Institution, Washington, D. C., a nonprofit agency functioning an independent basis, to undertake the preparation of a report on medical care for the individual that would be helpful to the committee in the consideration of the numerous bills on compulsory health insurance with which it was concerned. Accordingly, President H. G. Moulton of this renowned private research organization—devoted to public service through research and training in the social sciences and in no way connected with health activities—assigned to the important task two senior members of the staff.

The joint authors of the report are Dr. George W. Bachman and Dr. Lewis Meriam. Dr. Bachman, formerly on the faculties of Chicago, Johns Hopkins and Columbia universities, has had wide experience in experimental medicine and public health. While at Columbia he organized, administered and directed for eleven years the School of Tropical Medicine in Puerto Rico, and during World War II he had extensive experience in China as representative of the American Bureau of Medical Aid to China. Dr. Meriam, vice president of the Brookings Institution, has had extensive experience in connection with the statistical and administrative aspects of health problems in the Census and Children's bureaus, as director of a comprehensive survey of Indian administration which included health, and in several studies of state government administration. He is the author of a recent treatise on relief and social security. Three other distinguished members of the staff served with President Moulton as a committee for critical review.

In the preparation of the report emphasis was placed upon appraising all the available evidence with a view to clarify the primary issues involved in the provision of more adequate medical care. The study is confined to the economic, social and administrative issues involved in two broad plans for participation by the national government in the provision of medical care for the individual. These two major proposals are the grants-in-aid plan and the compulsory health insurance plan.

The highlights of the gratifying conclusions and recommendations set forth in this truly scientific analysis and highly significant report will be commented on editorially in succeeding issues of The Journal. Fortunately, because of the wide public interest in the subject of compulsory health insurance, the Brookings Institution has made the full study available in printed form.*

*The Issues of Compulsory Health Insurance. By George W. Bachman and Lewis Meriam. Pp. 271. Washington, D. C.: The Brookings Institution, 1948.

BABY BLACK MARKETEERING

Strange indeed to the American scene seem such headlines as "Babies for Sale," "Under Cover Baby Traffic" and "Black Market Placement of Babies." Nevertheless, social workers proclaim and the courts of the land echo that there exists in Florida and throughout the nation one of the most vicious of all rackets, illicit traffic in babies.

Adoption specialists agree that approximately one third of all the children in foster homes reach there by the black market route. The size of the adoption market is largely predicated on the number of illegitimate children since according to the best estimates 75 per cent of all children received by foster parents are born out of wedlock. In addition to outright selling, there are many casual, off-the-cuff arrangements made by the natural mother, friends, lawyers, kindly nurses, well meaning doctors, goodhearted neighbors and sympathetic business acquaintances.

Understanding the complete evil of this black market is everyone's business. Every baby obtained by this route runs the chance of turning into a problem, and every individual adjustment problem tends eventually to become a problem

for society. Foster parents who take children in this way have no protection whatever if the child should develop unfavorably physically or mentally. Basically, the answer to the problem is education.

The control of this illicit traffic in babies requires that all adoptions should be a matter of public concern. Much of the present abuse can be minimized by the enactment and enforcement of adequate laws respecting child placement agencies. Florida has no law regulating the placement of children in adoptive homes. Only about 10 per cent of all placements in this state are now being made through properly licensed child-placing agencies, according to Marcus C. Fagg, state superintendent of The Children's Home Society of Florida. The demand is so great that many foster parents prefer the short cuts of black market baby shopping and undercounter placements rather than wait a reasonable time, accepting the risks and ignoring the advantages of the protection offered them, the natural parents and the child by adoption experts.

Legislation now being proposed merits the hearty support of Florida's physicians. It would require any individual, any doctor or lawyer, any organization or agency, any maternity home, hospital or other institution to be licensed by the State Welfare Board before placing any child and would exact heavy penalties for ignoring or breaking the law. Sponsoring the drafting and passage of such a measure are The Children's Home Society of Florida, the State Welfare Board, the Florida Children's Commission and Councils of Social Agencies throughout the state, supported by numerous civic and other lay organizations.

Such regulation by law will insure a careful study of the child's background so that children who should never be placed for adoption will not be placed and families who receive children for adoption will have every protection. New Jersey, Maryland and California now have such protective laws, and several other states are in the process of developing such legislation. Florida should be in the vanguard of these states.

FLORIDA'S CHILD HEALTH SERVICES

What child health services are rendered the children of Florida? How does this state compare with the rest of the nation in striving to attain the objective stated in the National Health Program of the American Medical Association "that every child should have proper attention, including scientific nutrition, immunization and other services . . .?"

The Florida Pediatric Society set out to learn the answers to these and many other questions relating to the medical care of children in private practice, clinics and hospitals and by public or voluntary health agencies. This research was done to provide tools for devising plans to improve child health services.

Coincident with the Florida study, all other states of the nation were collecting the same type of information for their respective areas. Never before in the history of medicine has such a comprehensive study of the care of the nation's children been made. Now the story of all 3,076 counties of the United States can be told.

A report summarizing much of the data collected in the Florida study will be published this summer. It is a condensed report, for in order to make it brief enough for practical use in the state only the most salient points are presented.

Members of the Florida Medical Association, other physicians and dentists will receive copies. Your copy should reach you about the time you receive this Journal.

The physicians of the state are the logical group to make use of this factual material. They are the ones who should instigate and support all justifiable changes to be made for the improvement of child health services. To do so every physician needs the facts. It is important that you read the report.

A. M. A. CONVENTION

The Ninety-Seventh Annual Session of the American Medical Association, which was held in Chicago from June 21-25, drew an attendance of 11,963 physicians, the largest roster in the history of the association except for that of the Centennial Session held last year. Dr. R. L. Sensenich of South Bend, Ind., succeeded Dr. Edward L. Bortz of Philadelphia as president of the association.

The president-elect is Dr. Ernest E. Irons of Chicago, who has been serving as secretary of the Board of Trustees and who for many years has been a leader in organized medicine. Dr. Irons

at the present time is professor of clinical medicine in the University of Illinois. Other officers include Dr. R. W. Fouts of Omaha, vice president; Dr. George F. Lull of Chicago, secretary and general manager; Dr. J. J. Moore of Chicago, treasurer.

The 1949 convention will be held in Atlantic City from June 6 through June 10.

Florida's delegates were Drs. Homer L. Pearson, Jr., of Miami and Louis M. Orr, II, of Orlando. Dr. Pearson is a member of the Judicial Council of the A. M. A. Dr. Orr served on the Reference Committee of the House of Delegates which reviewed the Reports of Officers.

Florida was represented by 124 members of the Association. The official roster includes the following names:

BRADENTON: Lowrie W. Blake, Willett E. Wentzel. COCOA: Thomas C. Kenaston. CORAL GABLES: Gunnard J. Antell, Karl W. Vetter. CRESCENT CITY: Bernard E. Kane. FERNANDINA: Henry B. Dickens, Jr. FT. LAUDERDALE: Anna A. Darrow, Robert L. Elliston, Roland F. Fisher, Benjamin F. Hart, Richard A. Mills, Scottie J. Wilson. GAINESVILLE: F. Emory Bell. HOLLYWOOD: Robert J. Patterson. JACKSONVILLE: John A. Beals, Joel Fleet, Malcolm J. Ford, William G. Harris, Gordon H. Ira, Samuel S. Lombardo, Irving J. Strumpf. LAKELAND: Samuel J. Clark, Fred S. Gachet. MELBOURNE: Theodore J. Kaminski.

MIAMI: Ralph F. Allen, Reuben B. Chrisman, Jr., L. Washington Dowlen, Maurice I. Edelman, Frederick E. Farrer, M. Jay Flipse, Roger J. Forastiere, Charles E. Hebard, Carlos P. Lamar, George D. Lilly, A. Buist Litterer, Joseph Lomax, Franklin McElheny, Jack A. McKenzie, James K. McShane, Donald F. Marion, Claude G. Mentzer, E. Sterling Nichol, Russell K. Nazum, Samuel W. Page, Jr., Homer L. Pearson, Jr., Gerard Raap, Harold Rand, Julian A. Rickles, Donald G. Stannus, Richard F. Stover, Herbert W. Virgin, Jr.

MIAMI BEACH: Bernhard Baer, Lewis Capland, Harold H. Fox, Meyer J. Glick, Emil M. Isberg, Saul H. Kaplan, George N. Leonard, Alexander Libow, Rose E. London, David A. Nathan, Julius A. Oshlag, Joseph B. Pomerance, Francis A. Reed, Alexander Robbins, Maurice J. Rose, Alexander E. Rosenberg, Rene A. Torrado. OCALA: Harry F. Watt. ORLANDO: Clarence Bernstein, Thomas G. Bouland, Jr., Elwyn Evans, Edward T. Furey, Fred Mathers, Pleasant L. Moon, Jr., Louis M. Orr, II, Don C. Robertson.

PALM BEACH: Oscar L. Kelley, Fred E. Manulis, Alvin E. Murphy. PANAMA CITY: Charles H. Daffin, William C. Roberts. PENSACOLA: Luther C. Fisher, Jr., Harry J. Haisfield. ST. AUGUSTINE: S. Raymond Cafaro, Vernon A. Lockwood, Donald T. Rankin. ST. PETERSBURG: Arnold S. Anderson, Elmer B. Campbell, John H. Cordes, Jr., Harry R. Deane, Dean W. Hart, Norval M. Marr, Harrison G. Palmer. SARASOTA: John M. Butcher, Joseph Halton, J. Edward Harris, Cecil E. Miller, Reaves A. Wilson. SEBRING: Leldon W. Martin.

TALLAHASSEE: Harold O. Hallstrand, Benjamin A. Wilkinson. TAMPA: Frank S. Adamo, J. Robert Campbell, Edith M. Corlew, Joshua C. Dickinson, J. Brown Farrior, Americo J. Ferlita, Gaetano C. Ferrante, H. Phillip Hampton, Paul J. McCloskey, Nathan L. Marcus, Thomas F. Nelson, Anthony P. Perzia, Joseph D. Scolaro, Burdette Smith, Alvord L. Stone, Morris Waisman, Wesley W. Wilson. WEST PALM BEACH: Lawrence R. Leviton, Saul D. Rotter. WINTER HAVEN: Lee E. Parmley. WINTER PARK: Ruth S. Jewett.

SHREWS AND MALARIA NEW RESEARCH AID

In the research laboratory it would appear to be the tainting of the shrew—the elephant shrew, that is. This mouselike midget measuring about 3 inches in length has velvety fur and gets its name from its long, flexible nervously exploratory nose with a rubbery tip. Newest reinforcement in science's war against malaria, this tiny mammal gives promise of eliminating a grave stumbling block in research on this disease.

Regarded by scientists as perfect malaria subjects, 104 of these shrews arrived in Washington in June from their home on the upper Nile in the Anglo-Egyptian Sudan. Navy scientists with the University of California African expedition searched the brush for some weeks to gather this interesting cargo, captured in snares by natives. Since shrews are cannibalistic, it was necessary to cage them in pairs to keep them from devouring each other on the 8,500 mile one stop air journey, which seemed to bother them not at all. Insect eaters in their wild state, they have in captivity taken readily to a diet of oatmeal porridge, chopped hardboiled eggs and finely ground meat.

The discovery that these little animals are susceptible to malaria marked them as valuable research material. Malaria susceptibility is rare and spotty among mammals. Guinea pigs and rabbits, for example, do not have the disease. Chickens and canaries have been tried out with moderate success only for their blood type is too far removed from that of human beings. The shrew, however, has a circulatory, respiratory and nervous system similiar to man's and can be easily infected with a genuine case of malaria. In fact, about 20 per cent of the imported shrews were already malarial.

Navy doctors at the Naval Medical Research Institute are determining the species of malaria parasites with which the shrews may be infected. They will try to transfer these to commoner, cheaper and more prolific experimental animals such as mice, rats and hamsters, since the shrews are worth about $60 apiece. To obviate the need for further expensive importations from Africa, they will also endeavor to get the shrews to breed in captivity. Too, they will try out assorted new antimalaria drugs on the infected animals.

SYPHILIS RECORDS OF VETERANS MADE AVAILABLE TO PHYSICIANS

At the request of Dr. Paul B. Magnuson, chief medical director of the Veterans Administration, the following notice is published:

"The Veterans Administration has in its custody the majority of syphilis records of those Army personnel who were treated for this disease while in active service, and in many instances can procure informative data from the syphilis records of other than Army personnel. It is thought that many physicians treating veterans for syphilis as private patients would find a resume of the syphilis record useful since the details of treatment, results of spinal fluid examinations, and blood serologies are incorporated in the records.

Resumes of these records are available to physicians who are treating such veterans provided authorization for the release of the data is given by the veteran. Requests for the resumes accompanied by an authorization for the release of the data, dated and signed by the veteran, should be addressed to the Dermatology and Syphilology Section, Veterans Administration, Munitions Building, Washington 25, D. C. It is most important that the veteran's Service Serial Number and other identifying information, such as the date of enlistment, the date of discharge, rank, and organization be included.

Ordinarily, the resumes can be furnished in approximately two weeks from the date of the receipt of the request and signed authorization."

FLORIDA BLOOD BANK ASSOCIATION

The second annual meeting of the Florida Association of Blood Banks was held in Miami, May 7 and 8. Four major blood banks were represented, each of which is operated independently. Florida's blood bank organization differs from other state programs in that there is no central control, but there is, through the state organization, unformity of technic and reciprocity among the banks. Much interest was evidenced in forming new banks for areas not covered as well as sub-banks, to operate under the central organizations.

The major portion of the meeting was concerned with scientific presentations by some of the outstanding blood research men in the country. Principal speakers on the Rh and Hr factors were Drs. Alexander S. Wiener and Philip Levine, co-discoverers of the Rh factor; Dr. Ernest Witebsky, the Anti-A and Anti-B expert; and Dr. Louis K. Diamond, Harvard Medical School.

Other internationally famous authorities who spoke on blood and plasma in shock, burns, anemia and other conditions were Dr. Virgil H. Moon, Jefferson Medical School of Philadelphia; Dr. John Scudder, president-elect of the American Association of Blood Banks and director of the Blood Bank of the Presbyterian Hospital, New York; Dr. William Dameshek, editor-in-chief of the new medical publication. Blood; and Capt. Lloyd R. Newhouser, United States Navy, who spoke of the part the organized blood banks would play in the event of atomic catastrophe. Other speakers included Dr. Elmer L. DeGowin, State University of Iowa College of Medicine; Dr. Robert Elman, Washington University School of Medicine; and Dr. John Elliott, research director of the Dade County Blood Bank and past president of the Florida Association of Blood Banks.

It was pointed out that three times as many blood transfusions are being given at this time as in 1940. A considerable portion of the work of the organized blood bank project is public education and publicity. With such increased demands made upon blood reserves and blood bank products, it is imperative that the public come to accept the idea of supporting the blood banks.

Lengthy discussions were held on the Rh and Hr factors as well as nomenclature. Dr. Diamond discussed in his paper the newest developments in indication and technic for exsanguination transfusion.

There was much interest in the subject of the use of universal Group O blood for transfusion to AB, A and B recipients, consideration being given the use of Witebsky's A and B Substances when Group O was given to other types. The use of Rh negative blood for positive patients was discussed, incidents being recorded of sensitization of such patients through the use of negative blood.

It is anticipated that scientific gatherings will be held from time to time in order that information may be made available for the medical profession as developments are made in the field of blood research, through the organized blood banks. The next annual meeting of the association will be held in Tampa in February.

RESEARCH FELLOWSHIPS AMERICAN COLLEGE OF PHYSICIANS

The American College of Physicians announces that a limited number of Fellowships in Medicine will be available from July 1, 1949 to June 30, 1950. These Fellowships are designed to provide an opportunity for research training either in the basic medical sciences or in the application of these sciences to clinical investigation. They are for the benefit of physicians who are in the early stages of their preparation for a teaching and investigative career in Internal Medicine. Assurance must be provided that the applicant will be acceptable in the laboratory or clinic of his choice and that he will be provided with the facilities necessary for the proper pursuit of his work.

The stipend will be from $2,000 to $3,200.

Application forms will be supplied on request to The American College of Physicians, 4200 Pine Street, Philadelphia 4, Pa., and must be submitted in duplicate not later than Nov. 1, 1948. Announcement of the awards will be made as promptly as is possible.

STANDARDIZATION OF INTRAVENOUS SETS REQUESTED

At the joint meeting of the medical societies of Sarasota and Manatee counties in May, Dr. Joseph Halton presented a letter containing a resolution pertaining to the difficulties encountered incident to the recent sudden withdrawal of the intravenous solutions of one manufacturer. The resolution was adopted, and it was directed that a copy of the letter be sent to The Journal for publication. The letter follows:

May 11, 1948

Journal of the Florida Medical Association
Jacksonville 1, Florida

Dear Sirs:

The confusion in times of crisis caused by manufacturers of intravenous fluids not having standardized intravenous sets has been forcibly brought to our attention through the unfortunate contamination and calling in all intravenous fluids of one manufacturer. Therefore, I have introduced the following resolution in our joint medical meeting of Sarasota and Manatee counties.

"BE IT RESOLVED, That all manufacturers of intravenous solutions be requested to standardize the intravenous sets so they can be interchangeable and can be used on any container of intravenous fluids."

SUL AMERICA PRIZE

At the request of the Counsul General of Brazil in Miami, The Journal is pleased to make the announcement which follows:

The Sul America Prize, established for the first time in 1947 by the insurance companies of Sul America group, will be awarded in 1948 by the Brazilian Institute of Education, Science and Culture (IBECC) to the best work on "Tuberculosis Prophylaxis," written by one or more physicians, citizens of any American country. The requirements are as follows:

1. The monographs, original and never before published, will be presented to the office of the IBECC at Palacio Itamaraty, headquarters for the Ministry of Foreign Relations, in two typewritten copies with not less than one hundred pages, signed by the author and written in Portuguese, Spanish, French or English. The works must be presented not later than Nov. 30, 1948.

2. The Board of Directors of the IBECC will organize a commission of three capable members, competent in that branch of medicine, and preferably members of the Institute. The commission will give its opinion about the works that have been presented and will indicate the one to be awarded the prize.

3. The prize will be in the amount of Cr$50,000.00 (approximately US $2,500.00) and will consist of a diploma signed by the president of the IBECC and the commission members.

4. The commission may propose the partition of the prize between two works, or decide not to grant same.

5. The final judgment and the name indicated for the award will be subject to approval by the IBECC Board of Directors.

6. In case the prize is not granted, the contest will be reopened for a period of twelve months, with the requirements the same as herein stated.

7. The prize will be awarded in a solemn session of the IBECC, to be presided over by the Minister of Foreign Relations in the Palacio Itamaraty during the second part of December 1948.

FLORIDA BLUE SHIELD ENROLMENT

For many years doctors have had as patients people who carried commercial insurance designed to cover surgical procedures. The doctors are entirely familiar with the lengthy and oftentimes complicated forms, which in the majority of cases it was necessary to complete before the insured could collect from the commercial carrier. Also, too frequently a long delay in settlement has occurred. Although many old line insurance companies wrote standard provisions in their policies which were practically uniform in their benefits and simple in their interpretation, too many companies issued policies which were subject to multiple interpretations and which, too often, proved of little or no value to the insured. Over the years the "red tape" encountered by the insured with this type coverage has been sufficiently great to create a doubt on the part of the public in general as to its value. This accounts for the comparatively small percentage of the population who have this type insurance coverage.

The public in general is, however, intensely interested in a prepayment medical care program which will eliminate questionable features, arguments and delays in payment for services. Nonprofit operation appeals to them since it assures maximum benefits at a minimum cost. A program which stresses "services" rather than "cash indemnity" also has its strong appeal. That this is so, and that the public has confidence in such programs, is evidenced by the tremendous growth of the Blue Cross Plans, which are plans for the prepayment of hospital bills, and which today boast a membership of over 30,254,000 people. The companion Blue Shield Plans, organized more recently, have also shown a phenomenal growth, having, in a short time, enrolled approximately 10,000,000 people in sixty-seven plans throughout this country.

Why have the Blue Cross and Blue Shield Plans grown so rapidly? There are two main reasons. First, the service benefits of both Plans have public appeal. Second, the public have confidence in their hospitals and their doctors. They feel that if they have contracts with their own hospitals and with their own doctors to render them services and that if these service plans are administered on a nonprofit basis, they will get what they pay for at minimum cost and trouble.

Public acceptance is a MUST for the success of any Blue Shield Plan. Because of pending socialized medicine legislation and because labor organizations are putting up a solid front to obtain this type of legislation, TIME, in which a large membership in the voluntary prepayment Plan must be enrolled, is also of the essence.

The doctors of the state of Florida can assist in this enrolment by signing participating agreements with the Florida Blue Shield Plan. They should do so whether they are surgeons, obstetricians or internists. When the Blue Shield representatives contact groups of employees in order to enrol them in Blue Shield and explain, as they do, that the Plan is presented to the people of Florida by the doctors themselves and then issue participating physicians lists to the employees, the first thing these employees do is to look for the name of their doctor. It is not important to them whether their doctor is a surgeon or an obstetrician. He may not be engaged in performing any of these services, but the fact that he is not on the list is all the evidence they need that the Plan itself is "no good." What they have to say about it, even though they are comparatively uninformed, still carries a great deal of weight with their fellow employees. Enrolment suffers.

There is bound to be some skepticism at first on the part of the public regarding any new plan, even though the doctors themselves are presenting it. This skepticism is easy to dissolve. It is usually engendered through lack of complete understanding of their own Plan on the part of the participating doctors themselves. As a case in point, it has been reported that one doctor inadvertently told a member of a large Blue Shield group, "Yes, I put some money up to help start the Blue Shield Plan, but I do not know much about it—suppose it is all right." Another participating doctor told a subscriber that he had signed a participating physician's agreement but that as far as he was concerned, regardless of the income of the subscriber, his fee would remain as it always had been and that the fee paid by the Fee Schedule would constitute a credit on the account and the subscriber would

have to pay the difference. The subscriber was a family man with five children earning $2,800 a year and was, therefore, entitled, in accordance with the participating physician's agreement, to full services with no additional charge over the amount paid by the Fee Schedule.

Fortunately for the success of the Plan, instances of the kind mentioned occur more infrequently now because the doctors are becoming thoroughly acquainted with their own Plan and with how it functions. They know that within forty-eight hours after submitting their bill for services a check is sent them. They know too that enrolment results prove (over 55,000 members in the Florida Plan) that their Plan is gaining in favor with the public. Their full cooperation with the Plan is responsible for this growth.

STATE BOARD OF HEALTH

TYPHUS CONTROL

The typhus fever rate declined sharply in 1947 in those Florida counties carrying out organized typhus control measures. A 46 per cent reduction in reported typhus cases was evident over the previous year for the six counties where control procedures have been in operation. In comparison, there was a 64 per cent increase in the combined number of reported cases from those counties where no organized control work was performed.

The first case of endemic typhus fever was officially reported to the State Board of Health in 1918. The number of cases has increased from year to year to a peak in 1944, when 484 cases were reported. During the thirteen year period from 1935 to 1947, a total of 2,972 human cases with 199 deaths was observed in the state. It has been demonstrated that only 1 human typhus case of each 3 cases that occur is reported; therefore, it can be seen that in a period of thirty years, typhus fever has become a disease of major importance in Florida.

The State Board of Health is now engaged in an all out program to control this devitalizing and debilitating disease. The present control program is concentrated in those counties from which the greatest number of cases have been reported.

Since murine typhus fever is primarily a disease of rats and is transmitted from rat to rat, and from domestic rats to man, through the agency of the rat flea, our efforts are naturally directed at controlling the domestic rats and their ectoparasites.

The control measures now being carried out in the organized counties consist of rat-proofing of buildings, distribution of poisoned rat-baits, rat-trapping, promoting better garbage disposal methods and distribution of 10 per cent DDT dust in and around buildings.

To the present time, spectacular results have been accomplished in the reduction of rat flea infestations, with concurrent reduction in reported cases of human typhus, by dusting with a 10 per cent DDT powder the premises of all residences and business establishments in the certain endemic typhus foci areas chosen for control work. In these areas rat runs and rat habitats are thoroughly dusted with DDT powder. In moving about the rats pick up particles of the toxic dust which greatly reduces the numbers of fleas on the rats. This flea reduction lessens the likelihood of the transmission of the disease from rats to man.

An example of the effectiveness of this method for the control of typhus was observed in a section of the city of Tampa. Prior to any dusting operation, rats were trapped and rat serums were collected and subjected to typhus complement fixation tests. The rats were also combed for fleas and other ectoparasites. Of the rat serums examined, 84 per cent gave typhus-positive complement fixation tests. An average of 15 fleas per rat was recovered from the rats combed. In 1947 only 4 typhus-positive rat blood serums were collected in the Tampa dusted area from a total of 132 serums tested. The rat-flea index was 0.134, or, 1 flea per 7 rats. Not a single human typhus case was reported in 1947 from this area where many cases had previously occurred.

In other areas where dusting was carried out over a two year period, comparable results were achieved. Rat-flea populations were markedly reduced. Positive rat blood serums have become rare in the areas of operations. This reduction in positive typhus rat blood serums and in rat-flea populations was obtained in those areas of human typhus foci so that a concurrent lowering of the human typhus rate in Florida resulted. The evidence which has been accumulated indicates that rat-flea and rat control is the most practical method of striking at the occurrence of murine typhus in human beings.

PUBLIC RELATIONS

Out of West Florida on June 27 came an outstanding project in medical public relations. As a part of the regular Sunday edition of the Pensacola News-Journal there was published an 18-page medical supplement sponsored by the Escambia County Medical Society.

Reviving a successful venture of prewar days, prior to the advent of newsprint shortage, the doctors of the Pensacola area again utilized this means of presenting to the public the too little known story of the contributions of the medical profession. A committee from the medical society was responsible for assembling and editing copy and photographic material submitted for publication by doctors, nurses, health officials, welfare agencies and many others.

The entire staff of the News-Journal gave generously in time and effort to produce an attractive and readable presentation. The Escambia County physicians are particularly grateful to the editor, Mr. Marion Gaines, upon whom the brunt of the responsibility rested. They also wish to express their appreciation to Mr. John H. Perry, president, and Mr. Braden Ball, publisher, of the News-Journal Company.

Without the cooperation and support of the business firms in Pensacola and surrounding areas the accomplishment of such an enterprise would have been impossible. Through the assistance of Mr. Robert Rainey, News-Journal advertising director, these organizations supplemented the messages of the news columns with appropriate and timely advertisements.

Early commentary on the medical supplement indicates that the reception by the public is generally favorable. The Escambia society seems to have found one answer to an increasingly difficult problem—that of submitting helpful medical and health information to the lay public in a form which is appealing, and which the readers can understand.

FOR RENT: Doctor's office in a new medical arts building; ideal location. Two doctors share reception room. Will give long or short lease. Contact owner, C. A. H. Jordan, 2173 S. W. Sixth Street, Miami. Mailing address, M. J. Laboratories, P. O. Box 51, Riverside Station, Miami 35, Fla.

WANTED: Ear, nose and throat specialist for association in office of Miami physician on percentage basis. Write 69-18, P. O. Box 1018, Jacksonville, Fla.

STATE NEWS ITEMS

Dr. C. LeRoy Adams, Jr., of Live Oak has returned to his offices after completing a postgraduate course at the University of Iowa College of Medicine in Iowa City.

Dr. William P. Logan of Lakeland spoke at the June meeting of the local Rotary Club, discussing the development of a statewide blood bank system in Florida.

Dr. Ernest R. Bourkard of Miami has joined the staff of the Mason Smith Clinic in Tampa. His association was effective on August 1.

Miami has been chosen as the convention city for the forty-second annual meeting of the Southern Medical Association which will be held from Oct. 25 through Oct. 28, 1948.

Dr. Elwyn Evans of Orlando attended various medical meetings in Chicago during the month of June. He presented a paper before the III Inter-American Cardiologic Congress entitled "The Electrocardiogram in Pneumoperitoneum Including Augmented Unipolar Limb Leads and Unipolar Esophageal and Chest Leads; New Chest Lead Terminology." The work was done in collaboration with Dr. Thomas C. Black of the Florida State Tuberculosis Sanitorium. Dr. Evans advises that abstracts are to appear in the American Heart Journal, the French Heart Journal and the South American Heart Journal. At a meeting of the American Geriatric Society, Dr. Evans presented a paper on "The Carotid Sinus Syndrome." He also has been nominated to the Advisory Council of the American Heart Association.

Dr. Elliott M. Hendricks of Ft. Lauderdale discussed the possibilities of addition hospital facilities in Broward County before members of the local Rotary Club on June 11. Dr. Hendricks spoke of the prospects of obtaining the physical plant of the hospital facilities at the naval base in Ft. Lauderdale and stated that a committee is at work on plans.

Dr. Rollin D. Thompson of Orlando is the newly elected president of the National Tuberculosis Association. He was elected in June at a meeting of the organization's board of directors in New York City.

Dr. Joseph S. Stewart of Miami addressed members of the staff of Monroe Memorial Hospital in Ocala in June. Dr. Stewart's remarks were in reference to the progress of surgery during the past fifty years. The topic of the paper which he presented was "Regional Enteritis When Discovered at an Operation for Acute Appendicitis."

Twelve members of the Florida Medical Association were registered at the meeting of the American Psychiatric Association which was held recently in Washington, D. C. They were Dr. Walter G. Miles of Chattahoochee, Drs. Sullivan G. Bedell and William H. McCullagh of Jacksonville, Drs. James L. Anderson, W. Tracy Haverfield, Paul Kells, John J. McAndrew and Edward H. Williams of Miami, Drs. Jess V. Cohn, Bernard Goodman and Lester Stepner of Miami Beach and Dr. Samuel G. Hibbs of Tampa.

Dr. Harold S. Knowles of Orlando participated in a current research project on cancer in June at Children's Hospital and the Harvard University Medical School in Boston.

Dr. Harold D. Van Schaick of Miami spoke to members of the medical division of the Coral Gables Veterans' Administration Hospital on June 11. His subject was "Medical Ethics and Public Relations."

Dr. Karl B. Hanson of Jacksonville enroled in June for a postgraduate course entitled "Physiological Basis for Internal Medicine," which was offered by the American College of Physicians at the University of Illinois College of Medicine in Chicago.

Dr. Thomas H. Lipscomb of Jacksonville addressed members of the Jacksonville Optimist Club at their regular luncheon meeting on June 25. In his address Dr. Lipscomb stressed the need for early diagnosis of cancer.

Seven members of the Association lectured at an advanced course in "education of the partially sighted" which was held at the Florida State University from June 14 through July 12. Twenty-two teachers attended the course which stressed the technics of training visually handicapped children. Lecturers included Dr. William Y. Sayad of West Palm Beach, Dr. Charles C. Grace of St. Augustine, Dr. Hollis C. Ingram of Orlando, Dr. Bascom H. Palmer of Miami, Dr. Shaler Richardson of Jacksonville, Dr. Sherman B. Forbes of Tampa and Dr. Nathan S. Rubin of Pensacola.

BIRTHS AND DEATHS

BIRTHS

Dr. and Mrs. Lee E. Bransford, Jacksonville, announce the birth of a son, Richard Hobbs, on June 26, 1948.

DEATHS—MEMBERS

Dr. Samuel Puleston, Sanford	May 29, 1948
Dr. Lawrence L. Stepp, Ft. Lauderdale	May 30, 1948
Dr. Henry C. Dozier, Lavallette, N. J.	June 16, 1948
Dr. Frederick W. Krueger, Jacksonville	July 6, 1948

F. M. A. ANNUAL MEETING

The 75th Annual Meeting of the Florida Medical Association is scheduled to be held in Belleair, April 10-13, 1949. The announcement was made by Dr. Duncan T. McEwan, chairman of the Board of Governors.

MEDICAL DISTRICT MEETINGS

The chairman of the Council, Dr. Herman Watson, has just announced that the dates of the four Medical District meetings have been officially set by the Council as follows:

Live Oak, Monday, Oct. 18, 1948
Daytona Beach, Tuesday, Oct. 19, 1948
Bradenton-Sarasota, Wednesday, Oct. 20, 1948
West Palm Beach, Friday, Oct. 22, 1948

COMPONENT SOCIETY NOTES

BAY

Members of the Bay County Medical Society have paid 1948 dues to the Association.

MADISON-SUWANNEE

All members of the Madison-Suwannee County Medical Society have paid 1948 dues to the Association.

MARION

The May Meeting of the Marion County Medical Society was held at the Hotel Florida in Ocala with the following members present: Drs. Hugh H. Barfield, Richard C. Cumming, T. Hartley Davis, Bertrand F. Drake, Henry L. Harrell, Eaton G. Lindner, Carl S. Lytle, William J. McGovern, Eugene G. Peek, Sr., Thos. H. Wallis and Harry F. Watt of Ocala; Dr. James L. Strange of McIntosh and Dr. Herbert M. Webb, Jr., of Wildwood.

NASSAU

The 1948 dues have been received from the entire membership of the Nassau County Medical Society.

POLK

At the June meeting of the Polk County Medical Society, Dr. William P. Logan of Lakeland spoke on blood transfusions. Drs. Lamar L. Lancaster and Theodore C. Keramidas of Winter Haven discussed the paper.

PUTNAM

The June meeting of the Putnam County Medical Society was held in Crescent City on June 8 with the following members present: Dr. Joseph E. Rose of Bunnell, Dr. Grover C. Collins of Palatka, and Drs. Edward W. Ford, Bernard E. Kane and James W. Davidson of Crescent City. In the absence of an arranged program, various cases were discussed by the attending physicians. All members of the society have paid 1948 dues to the Association.

ANDRE ALEXANDER CUETO

Dr. Andre A. Cueto of Ft. Lauderdale died suddenly in his home on Sept. 19, 1947 following a heart attack. He was 42 years of age.

In 1934 Dr. Cueto was graduated from the University of Cincinnati College of Medicine and in 1939 was licensed to practice medicine in Florida. He had maintained offices in Ft. Lauderdale since 1940.

Surviving are his widow and three sons, Richard, Ronald and Robert.

PERRY CLEVELAND FARNELL

Dr. Perry C. Farnell of Branford died suddenly at his home on June 5, 1948 following a heart attack. He was 63 years of age.

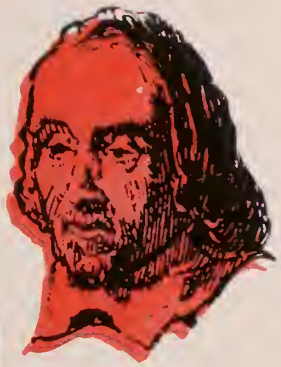
The son of Mason T. and Minnie Howell Farnell, Dr. Farnell was born in Columbia County, near Fort White on Aug. 4, 1884. He received his early education in the Columbia County schools and later attended the old State College at Lake City. In 1912 he was graduated from the Medical College of the State of South Carolina in Charleston. For fourteen years following his graduation he practiced medicine in Lake City and then opened offices in Branford, where he practiced until the time of his death.

He was a member of the Madison-Suwannee County Medical Society, the Florida Medical Association and the American Medical Association. He also was affiliated with Branford Lodge No. 130 F. & A. M. and with the Shrine. Dr. Farnell was a member of the Advent Christian Church.

Dr. Farnell is survived by his widow, Mrs. Alice Morris Farnell; one son, J. C. Farnell of Zephyrhills, one brother, Dr. C. M. Farnell, Live Oak; one sister, Mrs. H. K. Pierson of New Smyrna Beach, and two granddaughters, Misses Joyce and Sandra Farnell of Zephyrhills.

(Continued on page 108)

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ROLLIN JEFFERSON

Dr. Rollin Jefferson of Tampa died at his home on March 4, 1948. He was 69 years of age.

A native Georgian, Dr. Jefferson was graduated in 1903 from the University of Maryland School of Medicine and College of Physicians and Surgeons in Baltimore. After practicing medicine in Columbus, Ga., for two years, he opened offices in Tampa in 1905. His practice was limited to ophthalmology and otolaryngology.

He was a member of the Hillsborough County Medical Society, a life member of the Florida Medical Association and a member of the American Medical Association. Locally he was an Elk, a Mason and a Shriner.

Survivors include his widow, Cuthbert Sparkman Jefferson; a son, Dr. Curtis B. Jefferson, who practiced medicine with his father in Tampa; two brothers, Dr. Benjamin L. Jefferson, Grand Junction, Colo., and Dr. Albert Jefferson, Columbus, Ga.; and a sister, Mrs. Meta McPhail, Richmond, Va.

EUSTACE LONG

Dr. Eustace Long of Madison died at his home on Sept. 8, 1947. He was 70 years of age.

Born on Nov. 19, 1876 in Pike County, Ala., Dr. Long was the son of William Albert and Cynthia Ellen Long. Following his preliminary education, he was graduated from the Maryland Medical College in Baltimore in 1903. He began his Florida practice in Macclenny, once serving as president of its city council. He resided there until 1908 when he moved to Madison.

During the first World War, Dr. Long served as a captain in the Medical Corps of the United States Army. Upon his return he organized and was the first commander of the Homer F. Browning Post 20 of the American Legion. He was a member of the Haywood Masonic Lodge No. 45, and of the Sudan Temple of the Mystic Shrine at Newbern.

In 1937 Dr. Long served as president of the Madison County Medical Society, and in 1946 was president of the Madison-Suwannee County Medical Society. He was a member of the Florida Medical Association, which he served as a member of the Committee on Necrology for two years, and a member of the American Medical Association.

The widow, Louella Glass Long, survives. Also surviving are a son, E. C. Long, of Jacksonville; and a daughter, Mrs. William M. Henry, and a grandson, William M. Henry, Jr., of Plant City.

JOHN DENT PEABODY

Dr. John D. Peabody of St. Petersburg died on May 30, 1948 after a brief illness. He was 88 years of age and had retired from active practice several years ago.

Dr. Peabody, son of Dr. James Henry Peabody and Virginia Dent Peabody, was born on April 24, 1860 in Washington, D. C. Shortly thereafter he moved with his parents to Omaha, Neb.

He attended Georgetown University, the Long Island College of Medicine in Brooklyn, and was graduated in 1882 from the University of Pennsylvania School of Medicine in Philadelphia. Dr. Peabody practiced medicine in Omaha for ten years when ill health forced him to move to another climate. He established offices in St. Petersburg in 1899.

Dr. Peabody was a charter member and the second president of the Pinellas County Medical Society, an honorary member of the Florida Medical Association, and a member of the American Medical Association. He was one of the early chiefs of staff of the Mound Park Hospital.

He also was a charter and life member of Lodge 1224, BPOE, and a member of Nitram Lodge No. 188, F. & A. M. He was a veteran of the Spanish-American War, in which he served in the Medical Corps with the rank of captain.

A son, John M. Peabody of Lynbrook, Long Island, N. Y., a daughter, Mrs. Frank Barber of Asheville, N. C., and six grandchildren survive.

GORDON LEROY EDWARDS

Dr. G. LeRoy Edwards of Sarasota died on March 29, 1948 in Orlando. He was 36 years of age.

Dr. Edwards was graduated from the College

of Medical Evangelists in Los Angeles in 1945. He had been practicing in his native city since 1946.

He was a member of the Sarasota County Medical Society, the Florida Medical Association and the American Medical Association.

GEORGE A. DAVIS

Dr. George A. Davis of DeLand died after a prolonged illness on Feb. 20, 1948 in the DeLand Hospital where he had been a patient for more than two months. He was 89 years of age.

Dr. Davis was born on Nov. 8, 1858 in Fayette County, Ga. After completing his elementary education in Fayetteville, Ga., he attended the College of Atlanta, now known as Emory University School of Medicine, from which he was graduated in 1890.

He opened his offices in DeLand in 1894 when the city had a population of about 600 persons. At that time his practice extended throughout the entire West Volusia County area.

During the fifty-three years he resided in DeLand, Dr. Davis was active in civic and community affairs. He had served as city health officer and also as health officer of Volusia County. For many years he was the physician for the Florida East Coast and the Atlantic Coast Line railways. Civically, he was a charter member of the Rotary Club, a past president of the DeLand Chamber of Commerce, a member of the Masonic Lodge, the Elks, the Odd Fellows and the Woodmen of the World.

Dr. Davis was a member of the Volusia County Medical Society, a life member of the Florida Medical Association and a fellow of the American Medical Association.

Surviving are the widow, Mrs. Annie Cochran Davis, devoted companion for more than sixty-two years; two daughters, Mrs. Charles H. Campbell and Mrs. John O'Neill, of DeLand; a brother, John Davis, and a sister, Mrs. Tobias Brown, of Fayette County, Ga.; two grandchildren, Mrs. Hugh Garvey and Dr. Charles Campbell, Jr., and two greatgrandchildren.

(Continued on page 111)

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by Joe Marsh

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Joe Marsh

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MEDICAL DISTRICT MEETINGS

The chairman of the Council, Dr. Herman Watson, has just announced that the dates of the four Medical District meetings have been officially set by the Council as follows:

Live Oak, Monday, Oct. 18, 1948

Daytona Beach, Tuesday, Oct. 19, 1948

Bradenton - Sarasota, Wednesday, Oct. 20, 1948

West Palm Beach, Friday, Oct. 22, 1948

JOHN PITT TOMLINSON, SR.

Dr. J. Pitt Tomlinson of Lake Wales died in the family home on Sept. 7, 1947 at the age of 73 after almost fifty years of medical service in the state of Florida.

Dr. Tomlinson was graduated from the Southern Medical College in Atlanta in 1898 and began the practice of medicine during that year in Lake Butler. He practiced in Starke from 1914 until 1920. He then established a practice in Lake Wales when that city was in its infancy and had continued to practice there for twenty-seven years.

Locally, this pioneer physician took an active part in civic and organizational work. He was a Mason and a Shriner and was a charter member of the Lake Wales Kiwanis Club. Always interested in politics, for many years he served as Democratic committeeman for his district. He was a member of the Baptist Church in Lake Wales.

Dr. Tomlinson was a member of the Polk County Medical Society, a life member of the Florida Medical Association and a member of the American Medical Association.

In addition to his widow, Dr. Tomlinon is survived by two sons, Dr. J. Pitt Tomlinson, Jr., who was associated with his father in the practice of medicine in Lake Wales, and Laurie W. Tomlinson of Jacksonville; one brother, Lloyd Tomlinson of Baxley, Ga.; two sisters, Mrs. J. B. Fender and Mrs. H. C. Johnson of Valdosta, Ga., and five grandchildren.

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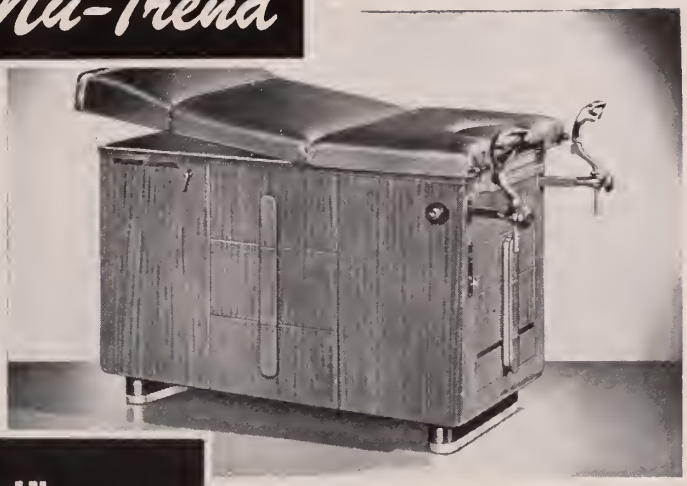
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	Escambia *Santa Rosa*	Joe I. Turberville, M.D. Century	Nathan S. Rubin, M.D. 5 E. Gregory St. Pensacola	2nd Tuesday 8:00 P.M.	61	58	
	Franklin-Gulf	T. Meriwether, M.D. Wewahitchka	J. R. Norton, M.D. Port St. Joe	3rd Tuesday Odd Months	7	4	A-1-50 William P. Hixon, M.D. Pensacola
	Jackson *Calhoun*	Courtland D. Whitaker, M.D. Burton Bldg. Marianna	Francis M. Watson, M.D. 120 Deering St. Marianna	3rd Thursday 7:30 P.M.	15	100%	
	Walton-Okaloosa	Ralph B. Spires, M.D. DeFuniak Springs	Arthur G. Williams, Sr. Lakewood	3rd Thursday 8:00 P.M.	13	100%	
	Washington-Holmes	N. J. Dawkins, M.D. Vernon	B. W. Dalton, M.D. Chipley		5	100%	
B	Columbia *Baker-Hamilton*	W. M. Ives, M.D. 20 W. Madison St. Lake City	Thomas H. Bates, M.D. 27 W. Madison St. Lake City	1st Monday 7:30 P.M.	14	100%	
	Leon-Gadsden-Liberty-Wakulla-Jefferson	Taylor W. Griffin, M.D. Quincy	Edward C. Love, Jr., M.D. Masonic Temple Bldg. Quincy	Quarterly 7:30 P.M.	46	43	A-2-49 Irby H. Black, M.D. Live Oak
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	Taylor *Dixie-Lafayette*	Walter J. Baker, M.D. Foley	Ralph J. Greene, M.D. Perry	Last Friday 8:00 P.M.	4	100%	186
C	Alachua *Bradford, Gilchrist Union*	J. Maxey Dell, Jr., M.D. 331 W. Main St., S. Gainesville	F. Emory Bell, M.D. Box 400 Gainesville	2nd Tuesday 8:00 P.M.	34	33	
	Duval *Clay*	John A. Beals, M.D. 1900 Boulevard Jacksonville	Elmer E. Leitner, M.D. 33 W. Ashley St. Jacksonville	1st Tuesday 8:15 P.M.	238	226	
	Marion *Levy*	Hugh H. Barfield, M.D. 1317 S. Orange St. Ocala	Bertrand F. Drake, M.D. Professional Bldg. Ocala	3rd Wednesday 12.30 P.M.	30	25	B-3-50 Charles C. Grace, M.D. St. Augustine
	Nassau	David G. Humphreys, M.D. Fernandina	John W. McClane, M.D. Fernandina	Last Friday 8:00 P.M.	9	100%	
	Putnam	Edward W. Ford, M.D. Crescent City	James W. Davidson, M.D. 6 S. Main St. Crescent City	2nd Tuesday 6:00 P.M.	8	100%	
	St. Johns	Hardgrove S. Norris, M.D. 168 Marine St. St. Augustine	S. Raymond Cafaro, M.D. Exchange Bank Bldg. St. Augustine	3rd Tuesday 8:30 P.M.	15	100%	
D	Brevard	I. Kimbell Hicks, M. D. Melbourne	Theodore J. Kaminski, M.D. Box 576 Melbourne	2nd Tuesday	15	13	
	Lake *Sumter*	Howard G. Holland, M.D. 1112 W. Main St., Leesburg	Matthew Arnow, M.D. Eustis	1st Wednesday 7:30 P.M.	25	22	B-4-49 Rabun H. Williams, M.D. Eustis
	Orange *Osceola*	Rollin D. Thompson, M.D. Box 3513 Orlando	James G. Economon, M.D. 108 E. Central Orlando	3rd Wednesday 8:00 P.M.	131	129	
	Seminole	Harry Z. Silsby, M.D. Box 642 Sanford	Frank L. Quillman, M.D. Box 158 Sanford	2nd Tuesday 5:30 P.M.	10	100%	
	Volusia *Flagler*	Charles E. Tribble, M.D. DeLand	Robert L. Miller, M.D. 258½ S. Beach St. Daytona Beach	2nd Tuesday 7:30 P.M.	51	50	566
E	Hillsborough	Douglas D. Martin, M.D. 442 W. Lafayette St. Tampa	Herschel G. Cole, M.D. 315 Wallace S. Bldg. Tampa	1st Tuesday 8:00 P.M.	142	139	
	Manatee	Millard P. Quillian, M.D. Walcaid Bldg. Bradenton	Willett E. Wentzel, M.D. Professional Bldg. Bradenton	3rd Tuesday 7:00 P.M.	18	100%	C-5-49 John M. Butcher, M.D. Sarasota
	Pasco-Hernando-Citrus	William G. Mason, M.D. Inverness	W. Wardlaw Jones, M.D. Box 247 Dade City	2nd Thursday 7:00 P.M.	14	13	
	Pinellas	M. Eldridge Black, M.D. 311 Coachman Bldg. Clearwater	Whitman C. McConnell, M.D. 313 First Federal Bldg. St. Petersburg	1st Monday 6:30 P.M.	158	156	
	Sarasota	John M. Butcher, M.D. 209 Commercial Ct. Sarasota	Talmadge S. Thompson, M.D. Box 224 Venice	2nd Tuesday 8:30 P.M.	23	22	
F	DeSoto-Hardee-Highlands-Charlotte-Glades	Zaven M. Seron, M.D. Sebring	Howard V. Weems, M.D. 22 Oak St. Sebring	2nd Tuesday 8:00 P.M.	25	24	C-6-50 H. Quillian Jones, M.D. Ft. Myers
	Lee *Collier, Hendry*	Harvie J. Stipe, M.D. 210 Richards Bldg. Ft. Myers	H. Quillian Jones, M.D. 311 Professional Bldg. Ft. Myers	3rd Tuesday 7:30 P.M.	21	100%	
	Polk	Chester H. Murphy, M.D. Bartow	John W. Vaughn, M.D. Box 475 Lakeland	2nd Wednesday 7:00 P.M.	77	74	478
G	Indian River	James C. Robertson, M.D. Vero Beach	William L. Fitts, 3rd, M.D. Vero Beach Arcade Vero Beach	2nd Tuesday 8:00 P.M.	8	100%	
	Palm Beach	Victor Clarholm, M.D. Box 672 West Palm Beach	Ralph M. Overstreet, Jr., M.D. 820 Comeau Bldg. West Palm Beach	3rd Monday 8:00 P.M.	87	84	D-7-50 Erasmus B. Hardee, M.D. Vero Beach
	St. Lucie-Okeechobee-Martin	Hugh B. Goodwin, Jr., M.D. Arcade Bldg. Ft. Pierce	Adrian M. Sample, M.D. Box 897 Ft. Pierce	3rd Thursday 8:00 P.M.	13	12	
H	Broward	Milton N. Camp, M.D. 720 Sweet Bldg. Ft. Lauderdale	Alva R. Taylor, M.D. 414 Blount Bldg. Ft. Lauderdale	4th Tuesday 8:00 P.M.	63	100%	D-8-49 Russell B. Carson, M.D. Ft. Lauderdale
	Dade	Robert T. Spicer, M.D. 1110 Huntington Bldg. Miami	Benjamin G. Oren, M.D. 628 duPont Bldg. Miami	1st Tuesday 8:30 P.M.	481	451	
	Monroe	James B. Parramore, M.D. 523 Whitehead St. Key West	Herman K. Moore, M.D. 811 United St. Key West	2nd Thursday 8:00 P.M.	12	100%	664

*Supervise and aid until organized separately.

Total 18

SCHEDULE OF MEETINGS

ORGANIZATION	PRESIDENT	SECRETARY	ANNUAL MEETING
Florida Medical Association	Joseph S. Stewart, Miami	Robert B. McIver, Jacksonville	Belleair, Apr. 10-13, 1949
Florida Medical Districts	Herman Watson, Lakeland	Council Chairman	
A-Northwest	Irby H. Black, Live Oak	William P. Hixon, Pensacola	Live Oak, Oct. 18, 1948
B-Northeast	Rabun H. Williams, Eustis	Charles C. Grace, St. Augustine	Daytona Beach, Oct. 19, 1948
C-Southwest	John M. Butcher, Sarasota	H. Quillian Jones, Ft. Myers	Bradenton-Sarasota, Oct. 20, '48
D-Southeast	Russell B. Carson, Ft. Lauderdale	Erasmus B. Hardee, Vero Beach	West Palm Beach, Oct. 22, 1948
Florida Specialty Societies			
Derm. and Syph., Soc. of	A. Buist Litterer, Miami	Wesley W. Wilson, Tampa	
Genl. Practice of Med.	M. Crego Smith, Clearwater	Walter E. Murphree, Gainesville	
Health Officers' Society	Roger F. Sondag, Jacksonville	Lorenzo L. Parks, Jacksonville	
Industrial & Railway Surgeons	F. Hardy Bowen, Jacksonville	J. H. Mitchell, Jacksonville	
Neurology & Psychiatry	James G. Lyerly, Jacksonville	William H. McCullagh, Jacksonville	
Ob. and Gynec. Society	Chas. J. Collins, Orlando	Dorothy D. Brame, Orlando	
Ophthal. & Otol., Soc. of	Bascom H. Palmer, Miami	W. Jerome Knauer, Jacksonville	
Orthopedic Society	Charles B. Mabry, Jacksonville	Eugene L. Jewett, Orlando	
Pathological Society	James N. Patterson, Tampa	Gretchen V. Squires, Pensacola	
Pediatric Society	Edgar W. Stephens, W. P. Beach	Hugh A. Carithers, Jacksonville	
Proctologic Society	Dean W. Hart, St. Petersburg	Frederick E. Farrer, Miami	
Radiological Society	James F. Pitman, Lake City	Floyd K. Hurt, Jacksonville	
Urological Society	Milton M. Coplan, Miami	Russell B. Carson, Ft. Lauderdale	
Florida—			
Academy, Public Medicine	Robert T. Spicer, Miami	Shaler Richardson, Jacksonville	
Basic Science Exam. Board	Paul A. Vestal, Winter Park	M. W. Emmel, D.V.M., Gainesville	
Dental Society, State	Horace L. Cartee, D.D.S., Miami	John I. Todd, D.D.S., Jacksonville	Hollywood, Dec. 12-15, 1948
Hospital Association	Mr. James T. Pate, Jacksonville	Mr. H. A. Schroder, Jacksonville	
Hospital Service Corporation	Mr. W. E. Arnold, Jacksonville	Mr. H. A. Schroder, Jacksonville	
Medical Examining Board			
Medical Postgraduate Course	Turner Z. Cason, Jacksonville	Chairman	
Medical Service Corporation	Leigh F. Robinson, Ft. Lauderdale	Herbert E. White, St Augustine	
Nurses Association, State	Miss Elizabeth Reed, Jacksonville	Helen Shearston, Miami	West Palm Beach, Fall, 1948
Pharmaceutical Association, State	Mr. D. M. Weaver, Miami	Mr. R. Q. Richards, Ft. Myers	
Public Health Association	Wilson T. Sowder, Jacksonville	Mr. Fred B. Ragland, Jacksonville	Panama City, Oct. 7-9, 1948
Tuberculosis & Health Assn.	Judge Ernest E. Mason, Pensacola	Mr. Walton MacJordan, Orlando	May, 1949
Woman's Auxiliary	Mrs. L. E. Parmley, Winter Haven	Mrs. C. R. Morgan, Jr., Miami	Belleair, Apr. 10-13, 1949
American Medical Association	R. L. Sensenich, South Bend, Ind.	Geo. F. Lull, Chicago	Atlantic City, June 6-10, 1949
Southern Medical Association	E. L. Henderson, Louisville, Ky.	Mr. C. P. Loranz, Birmingham	Miami, Oct. 25-28, 1948
Alabama Medical Association	J. Paul Jones, Camden, Ala.	Douglas L. Carnon, Montgomery	Montgomery, Ala., Apr. 19-21, 194
Georgia, Medical Assn. of	Edgar Hill Greene, Atlanta	Edgar D. Shanks, Atlanta	Savannah, Ga., May 10-13, '49
S. E. Hospital Conference	Mr. Frank Groner, New Orleans	Mr. Burton M. Battle, New Orleans	Biloxi, Miss.
Southeastern Allergy Assn.	J. Warrick Thomas, Richmond, Va.	Kath. B. MacInnis, Columbia, S. C.	
Southeastern, Am. College Phys.	Webster Merritt, Jacksonville	Florida Program Chairman	Atlanta, 1948
Southeastern Am. Urological Assn.	Harold P. McDonald, Atlanta	Russell B. Carson, Ft. Lauderdale	Boca Raton, March, 1949
Southeastern Surgical Congress	Gilbert Douglas, Birmingham, Ala.	B. T. Beasley, Atlanta	

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The JOURNAL of the Florida Medical Association, Inc.

Vol. XXXV SEPTEMBER, 1948 No. 3

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Meredith Mallory, Sr., and W. Dean Steward

War Surgery Up Front
William C. Roberts

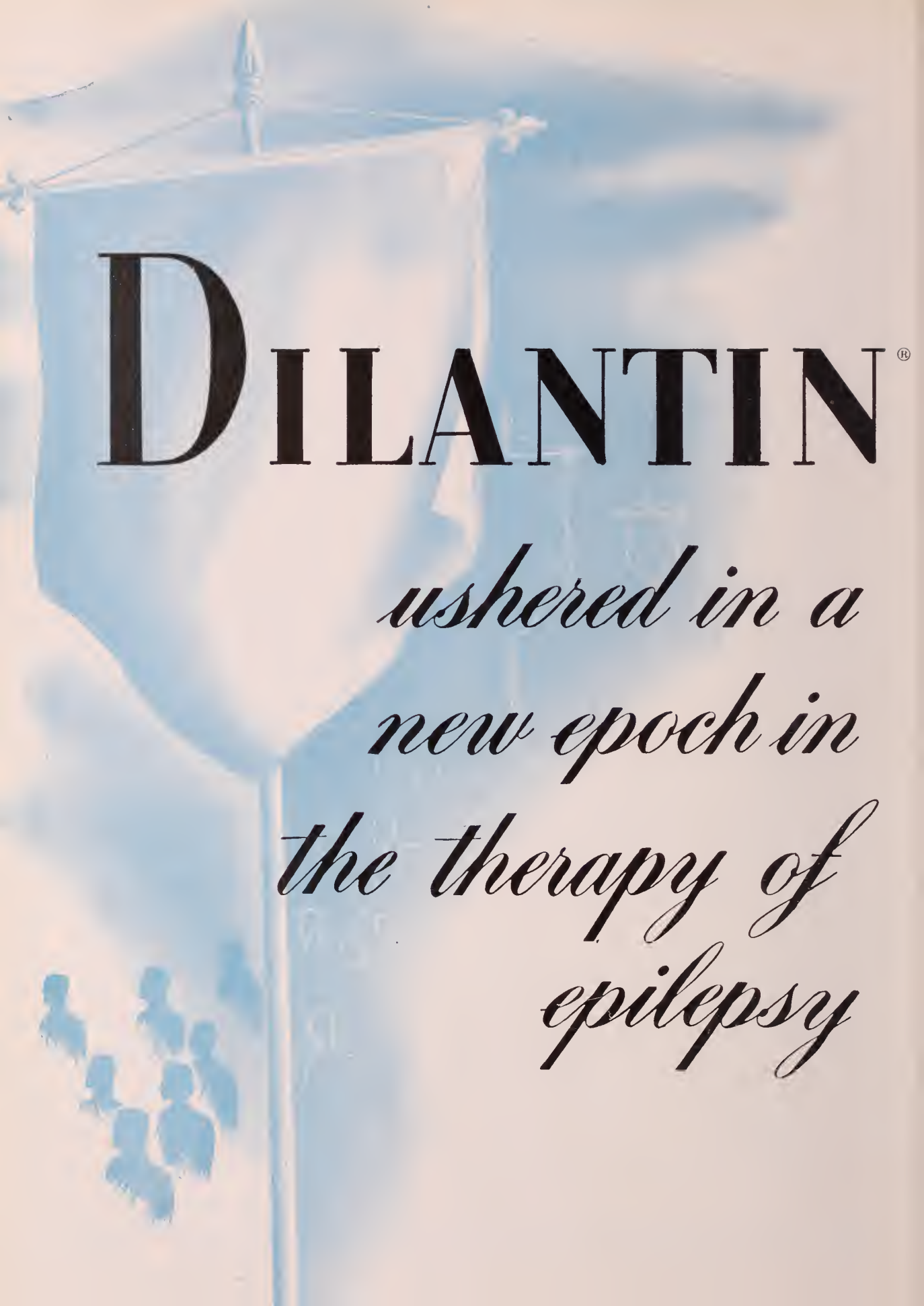
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Frederick Hardy Bowen

Influenzal Meningitis
Daniel F. H. Murphey

Hospital Problems — How Can They Be Solved?
An Editorial

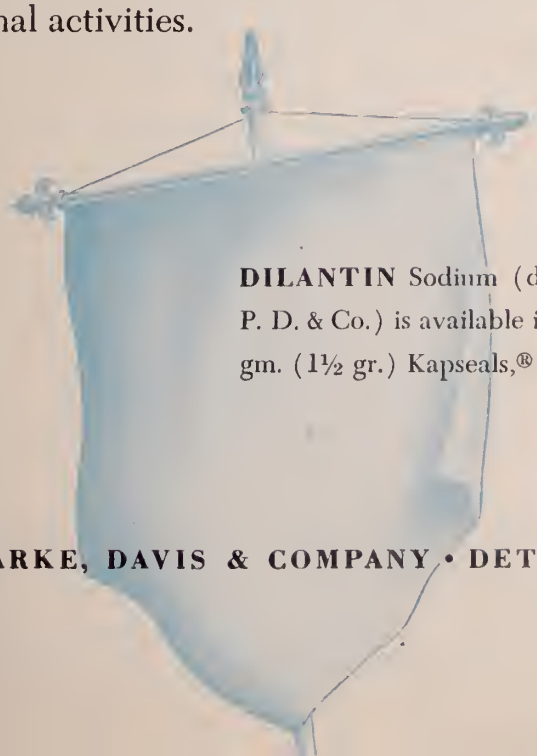
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Volume XXXV **SEPTEMBER, 1948** **No. 3**

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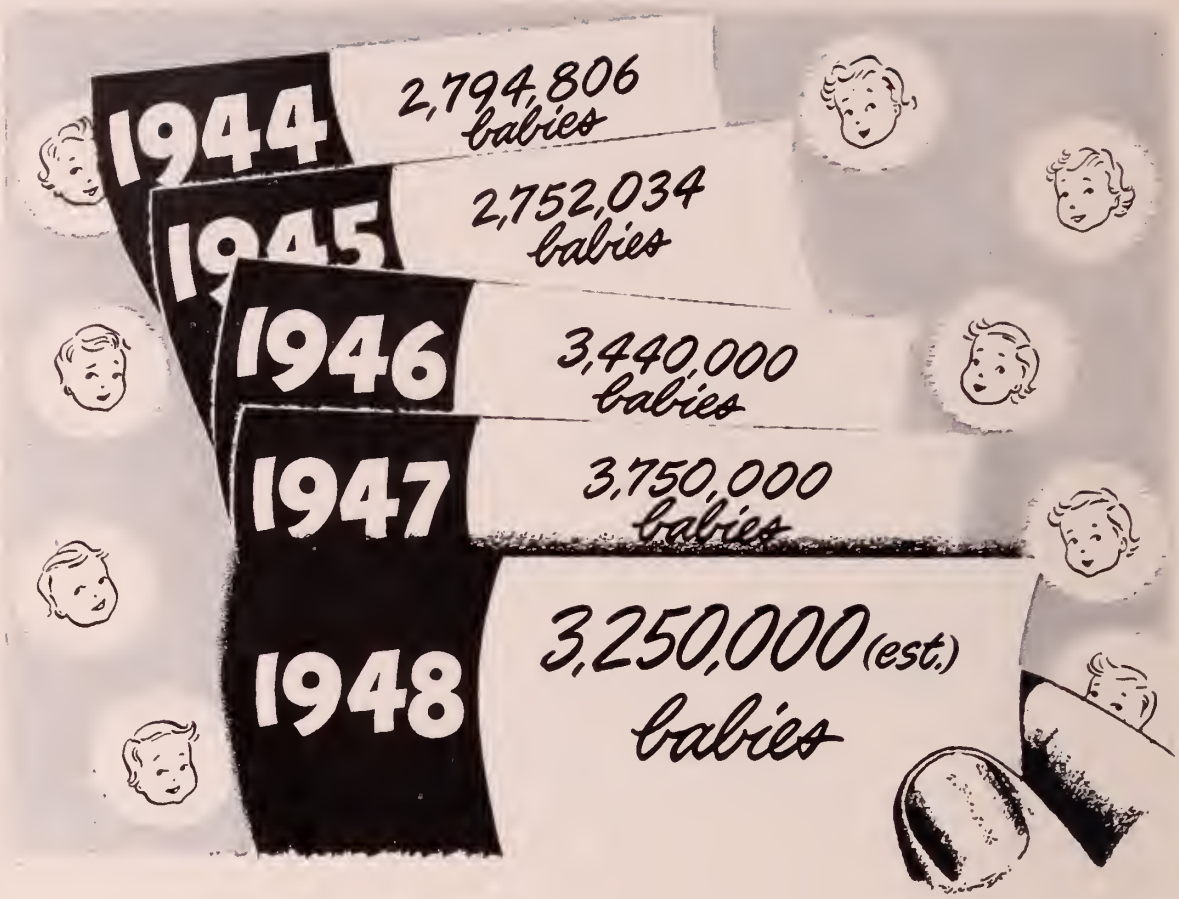
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This Journal is not responsible for the opinions and statements of its contributors.

Published monthly at Jacksonville, Florida. Price $5.00 a year; single numbers, 50 cents. Address Journal of the Florida Medical Association, P. O. Box 1018 (Fla. Theater Bldg.), Jacksonville 1, Fla. Telephone 5-0577. Accepted for mailing at special rate of postage provided for in Section 1103, Act of Congress of October 3, 1917; authorized October 16, 1918. Entered as second-class matter under Act of Congress of March 3, 1879, at the post office at Jacksonville, Florida, October 23, 1924.



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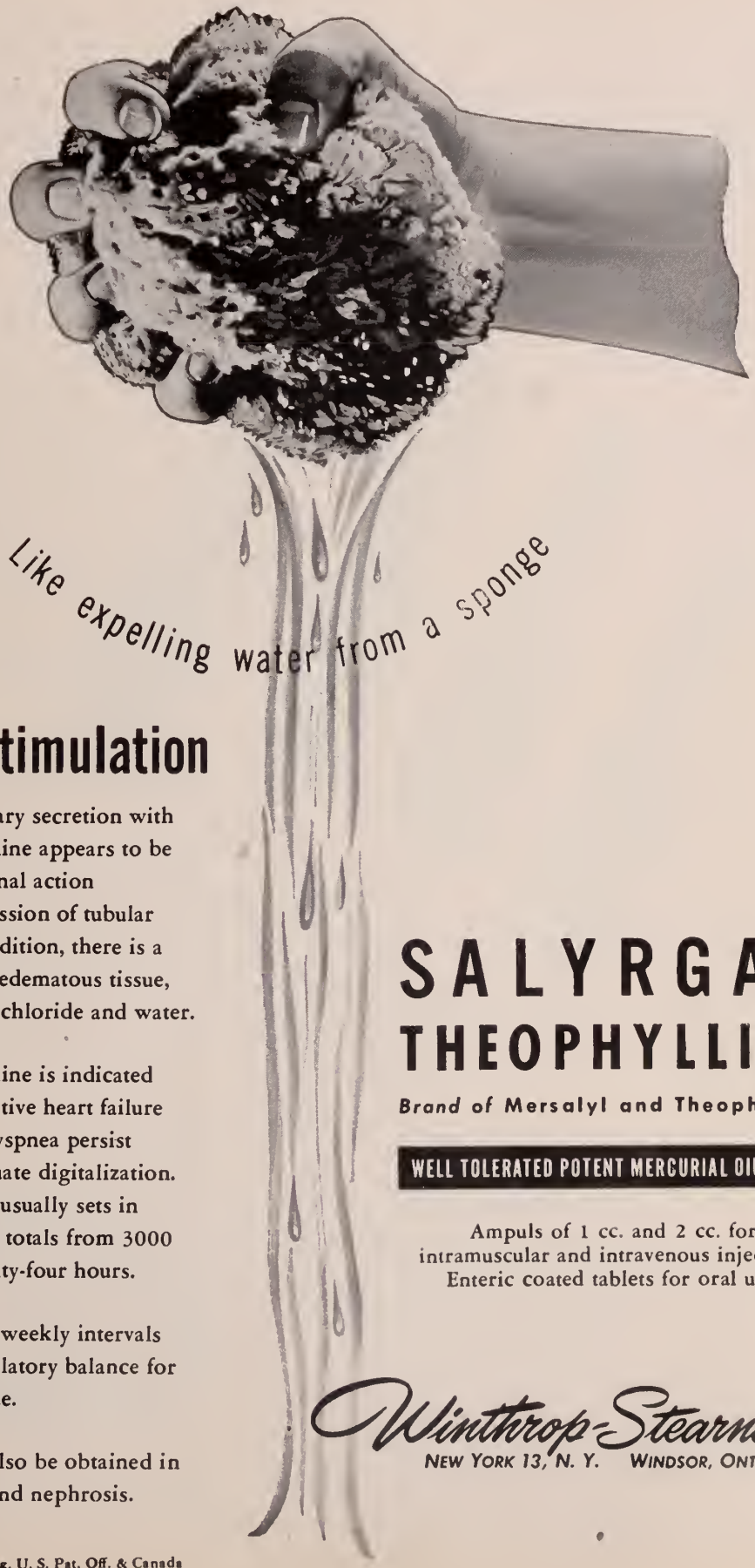
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1. Arbesman, C. E.: *N. Y. State Jl. of Med.*, 47: 1775, 1947.
2. Loveless, M. H.: *Am. Jl. of Med.*, 3: 296, 1947.
3. Bernstein, Rose and Feinberg: *Ill. Med. Jl.*, 92: 2, 1947.
4. Osborne, Jordon and Rausch: *Arch. of Derm. & Syph.*, 55: 318, 1947.

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Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154; Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60; Proc. Soc. Exp. Biol. and Med., 1934, 32-241; N. Y. State Journ. Med., Vol. 35, 6-1-25, No. 11, 590-592.



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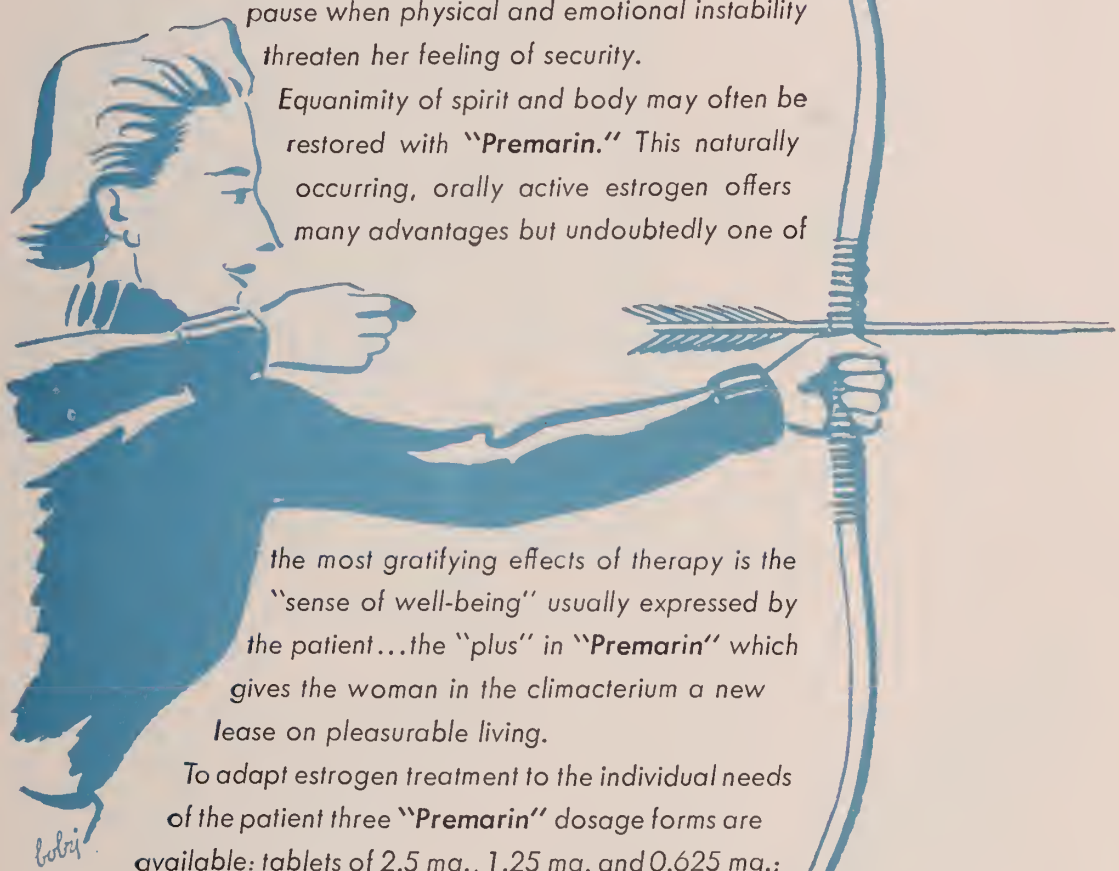
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*Snyder, M. L., Kiehn, C. L. and Christopherson, J. W.: Mil. Surgeon, *97*: 380, 1945. • Shipley, E. R. and Dodd, M. C.: Surg., Gynec. & Obst., *84*: 366, 1947 • Mays, J. L.: J. Med. Assoc. Georgia, *36*: 263, 1947. • Curtis, L.: Surg. Clin. N. America, 1466 (Dec.) 1947.

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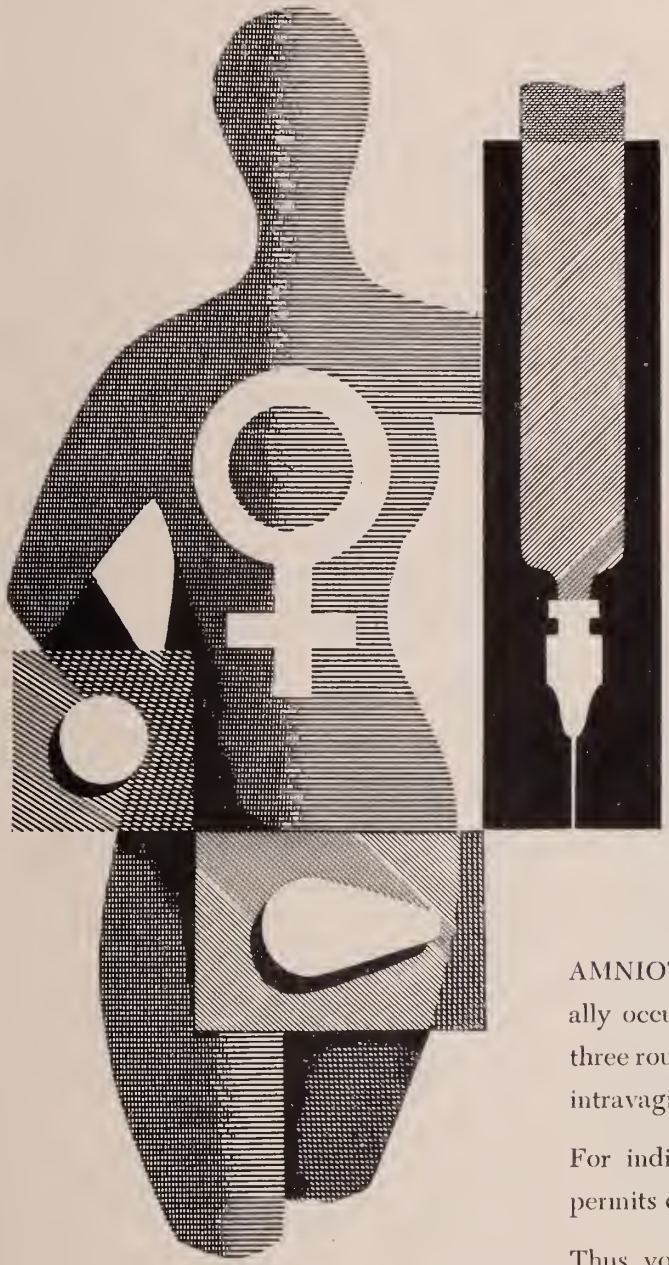
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[1] Forbes, E. B., and Swift, R. W.: J. Nutrition *27*:453 (June) 1944. [2] Forbes, E. B.; Swift, R. W.; Elliott, R. F., and James, W. H.: J. Nutrition *31*:203;213 (Feb.) 1946.

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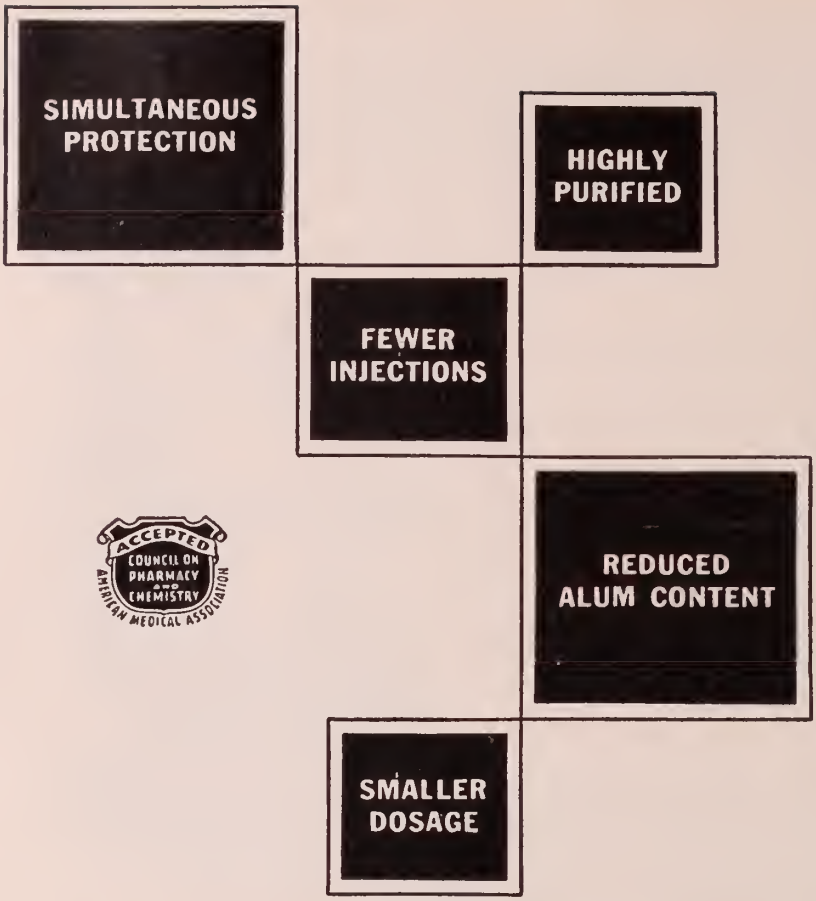


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THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION
PUBLISHED MONTHLY
Volume XXXV Jacksonville, Florida, September, 1948 No. 3

The Medical Management of Hypertension; A Review of the Newer Methods of Treatment

MEREDITH MALLORY, SR., M.D.
AND
W. DEAN STEWARD, M.D.
ORLANDO

A review of the recent literature fails to reveal any startling advances in the field of the medical treatment of essential hypertension. Numerous articles have been written, but these are for the most part reviews of past articles or further studies of previously tried drugs, though a few new approaches to the problem have been proposed. There has, however, been some effort to classify hypertension, and this in itself is an advancement, though the classification is admittedly inadequate.[1] Generally speaking, hypertensive disease can be subdivided into renal, glandular, neurogenic and essential. This paper is concerned only with the treatment of essential hypertension.

All patients should at the outset be given the benefit of a complete history and physical examination. Laboratory studies should be carried out to determine kidney function. Roentgen studies should be made of the kidneys, and possibly of the skull. It may or may not be advisable to carry out one of the tests advocated to rule out the presence of a pheochromocytoma, and it is often to advantage to carry out cold pressor and sodium amytal tests.[2]

Primarily the nonsurgical treatment of hypertension can be divided into three components: first, drug therapy; second, dietary therapy; third, psychotherapy.

DRUG THERAPY

For years drugs have been used in an attempt to lower the blood pressure. Some of these have definite temporary effect, such as the nitrites, and others have little if any effect.[3] A list of the drugs used in treatment of hypertension reminds one in part of the numerous cures advocated for the common cold, and in so far as we have been able to determine, they are about equally effective. Kapernick[4] studied the effect of theobromine, theobromine and phenobarbital, iocapral,* aminophylline, erythrol tetra nitrate, hepvisc,* and allimin* and was unable to discover any significant effect upon the blood pressure levels of hypertensive patients. He further mentioned the fact that symptomatic relief is not a sufficient criterion for the acceptance of a drug as a method of treatment, since such relief of symptoms apparently does not reduce the mortality rate in hypertensive cardiovascular disease.

Weaver, Wills and Hodge[5] studied nitroglycerin, sodium nitrate, erythrol tetranitrate and mannitol hexanitrate. They reported a small transient fall in blood pressure that started in from two to fifty-five minutes after administration of the drug and lasted from twenty minutes to four hours. They concluded that the drugs were of value as symptomatic aids only.

Ruskin and McKinley[6] investigated potassium thiocyanate, niacin, glucophylline, phenobarbital and mannitol hexanitrate. At the close of their article they mentioned that best symptomatic relief was obtained by the placebo (lactose or sodium bicarbonate) or by niacin. The cyanate at times caused an increase in the patients' symptoms. Hypotensive effects were demonstrable in many cases with all drugs, including the placebo. These they ascribed to the psychic reaction. They concluded that in the light of present knowledge the administration of potassium thiocyanate in clinical practice is hazardous and unreliable. Since thiocyanate therapy seems to be in vogue again following Barker's article,[7] it might be well to mention a few other reports. Fanson, Kinsey and Palmer[8] reported the use of thiocyanates in 100 cases. In 28 per cent there

Read before the Florida Medical Association, Seventy-Fourth Annual Meeting, St. Augustine, April 11-14, 1948.

*Proprietary drugs.

was significant fall in blood pressure, but in 20 per cent there were toxic reactions. Relief of headache was pronounced, and the drug was recommended for cases in which there was severe headache. Hines[9] of the Mayo Clinic, in an article in 1946, recommended the use of thiocyanate, either the potassium or the sodium salt, in the treatment of relatively young hypertensive patients with labile blood pressures and severe headaches. He mentioned also the numerous reactions that occurred, even though the blood level was kept between 8 and 12 mg. per hundred cubic centimeters when possible. Among the reactions were lassitude, weakness, mental confusion, dermatitis, purpura, nausea, vomiting and occasionally cyanate goiters. A later report[10] from the same clinic mentioned several cases of osteoporosis due to the drug. Some deaths have been reported.

Wakerlin and his associates[11a,b] and others[12] have reported the use in hypertension of an extract obtained from hog kidney which does not contain renin, antirenin or angiotonase. Though a slight fall in blood pressure was noted in some cases, it was only in those in which there was a febrile or toxic reaction to the extract. Vitamin A in large doses has been administered to dogs with experimental hypertension,[11c] but there are no available reports on its successful use in humans. Davis and Poser[13] reported the use of large doses of vitamin C in the form of ascorbic acid. They gave 1 Gm. daily in divided doses and obtained fair results. It was postulated that the vitamin may inhibit the formation of hypertensinogen, but the authors emphasized that much experimental work needs to be done.

Willson[14] reported on the use of veratrone, a derivative of Veratrum, in the treatment of hypertensive and pre-eclamptic patients. The drug was administered in doses of .5 to .75 cc. subcutaneously. In thirty minutes another dose of .25 cc. was given if there was no reaction. In most instances there was a fall in blood pressure that lasted several hours. In some cases there was a slight rise in the pulse rate. The action of the drug, like that of Veratrum viride, is through its peripheral dilating effect and its depressant action on the heart, the latter being mediated through the vagus. There were no recent reports confirming or discrediting this paper, and it is interesting to note that Veratrum has again appeared on the drugstore shelves in combination with phenobarbital and one of the nitrites. This drug may be of value, but there is insufficient evidence to recommend it at present. Tetra ethyl ammonium salts have been tried in hypertension, but their use is not recommended in the day-to-day treatment of the condition. Some value has been placed on the drug as a test prior to surgery.[15]

Griffith and his co-workers[16a,b] have approached the medical treatment of hypertension along slightly different lines. They have found a group of patients that did not respond to the thiocyanates, whose blood contained an antidiuretic substance or an increase in gonadotropic hormone, or both. These patients were treated either by pituitary irradiation, by the repeated injection of pitressin tanate in oil, or by the administration of male or female sex hormones. They reported a drop in pressure in about half of their patients, and clinical improvement of symptoms in slightly more than half.

This field is wide open for further investigation, but the difficulty lies in obtaining the necessary bioassays for the antidiuretic substance and the presence of increased gonadotropic hormone in the serum. It is probably safe to give the method a clinical trial in patients under 60 who have had no vascular accidents, but better results would undoubtedly be obtained if the suggested tests were run first to eliminate potential nonreactors.

DIET THERAPY

Off and on for over forty years it has been suggested that dietary factors might have a part in the appearance or aggravation of hypertension. For some time too, it has been noted that obesity is frequently a bedfellow of hypertension, and weight reduction has always been one of the things offered to obese hypertensive patients with the assurance that as the weight fell, so would the blood pressure. And often this is entirely true, as illustrated by a recent report by Adlersberg, Coler and Laval.[17]

The part that salt plays in the diet was first suspected by Ambard in France in 1905, and later by Allen and others in this country. At first the chloride was believed to be the harmful element. Later studies have indicted the sodium ion.[18] It is our observation that application of Kempner's routine[19a,b] with his rice diet provides better results and is more logical than any other dietary regime. His work first appeared in 1945 and heralded a new era in dietary restriction. He has had excellent results, not only in the

reduction of blood pressure, but also in the reduction of the size of the heart, the absorption of retinal exudates and the reduction of edema. It is also noteworthy that he has caused revision in the concepts of the minimum protein intake required by the body for nitrogen balance.

Basically his rice-fruit-sugar diet, or as it is more commonly known, the "rice diet," furnishes 2,000 calories. The diet contains approximately 5 Gm. of fat and 20 Gm. of protein derived from the rice and fruit, and not more than 0.2 Gm. of chloride and 0.15 Gm. of sodium. From 200 to 300 Gm. of dry rice with sugar and fresh or preserved fruits is allowed daily. Fluid intake is limited to from 700 to 1,000 cc. of fruit juices daily, no water being allowed. The diet is supplemented by vitamins and iron. Kempner's theory is that food substances, particularly animal proteins, contain unknown substances that contribute to or aggravate hypertension. After a varying period of time, depending on response, the diet is liberalized by the addition of nonleguminous vegetables and small amounts of potatoes, liver, beef, chicken, fish or eggs. No salt or fat is allowed.

Grollman,[18] on the other hand, believes that sodium restriction is the essential factor and allows a much more liberal diet in so far as variety is concerned, but he restricts caloric intake to 2,000 calories and sodium intake to less than 1 Gm. The milk allowed in his diet is dialyzed to remove sodium, and all foods are low in sodium content and are prepared without the addition of salt. It is too early to judge the diets statistically, but it is certainly safe to say that Grollman[18] does not have the faith in his diet that is evidenced by Kempner[19a,b] in his.

Occasional injections of mercurial diuretics have been suggested in order to allow the use of a slightly more liberal intake of salt. Their action on the kidney tubules increases salt excretion through decreased absorption.[20,21]

PSYCHOTHERAPY

Studies have revealed the absence of renin and angiotonin in the blood of patients with essential hypertension. Because of this, and because of the relatively small number of hypertensive patients relieved by the cure of unilateral renal disease, there has been more investigation into the neurogenic side of the disease. And it is true that the most valuable medical weapon for use in the average case of hypertension is psychotherapy. This may range from the use of reassurance and good common sense to advanced psychotherapy. The patient must be taught to live with his disease, to adjust his work and play schedule to relieve himself of strain as much as possible and to budget his leisure hours for the maximum relaxation. It is helpful to encourage the patient to express his aggression and resentments by directed work and play, and by physical exercise that will not tax the cardiovascular system. Every effort should be made to alleviate the patient's dread of his disease, and the hopeful aspects of the picture should be presented to him. Useful adjuncts to the psychotherapy employed are rest, sedation and the omission of smoking. The patient should be encouraged to sleep eight to ten hours nightly, to rest in bed over the weekend whenever possible, and to rest for one-half to one hour once or twice during the day if at all possible. The use of sedatives is also of great value. These relieve nervous tension and promote rest and sleep. The most commonly employed are phenobarbital or amytal, or the bromides.[22,23]

CONCLUSIONS

There is still no medical cure for hypertension. It is our opinion that the judicious use of sedatives, a low sodium diet, preferably the rice diet, and proper application of basic principles of psychotherapy seem to offer the most for alleviation of this condition up to the present time.

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This is the second of four papers on "Hypertension" presented at the St. Augustine Convention. The first appeared in the August issue.

Discussions of the entire symposium will be published at the end of the fourth paper.

War Surgery Up Front

WILLIAM C. ROBERTS, M.D.
PANAMA CITY

The Good Book records: "You will hear of wars and rumors of wars."[1] History has proved this statement to be a positive fact. There are today sporadic armed conflicts going on about the world. There are today strong rumors of wars yet to be fought. We sincerely hope that in the future the statement in the Good Book will serve as an historical record only, and not a statement of realistic prophecy. In spite of the bad that results from war, there necessarily emerges some good, and we should try to profit from both returns. The bad speaks for itself. The havoc wrought should itself prevent war. The good that emerges from war is that it stimulates our lethargic endeavors and forces us to greater achievement, be it industrial, economic or scientific accomplishments.

We as medical men and women are perhaps more concerned with the scientific phase in general, and particularly the preservation, repair and salvage of the human body. World War II gave us much experience from which much benefit has been derived from a medical and surgical standpoint. The knowledge gained should pay dividends in the event of future conflict as well as in peacetime medicine and surgery at home.

Many excellent contributions have appeared in the literature with reference to war surgery. I will not go into detail about policy, procedure and technic in the care of battle casualties, but I take great pleasure in directing your attention to two articles about war surgery published in recent journals, namely, "Notes on Abdominal Wounds Received in Battle" by Drs. Fred W. Rankin and Lawrence E. Hurt[2] of Lexington, Ky., appearing in the December 1947 issue of The Southern Surgeon, and "Wounds of the Colon and Rectum" by Dr. C. Frank Chunn[3] of Tampa, appearing in The Journal of the Florida Medical

Read and illustrated with motion pictures before the Florida Medical Association, Seventy-Fourth Annual Meeting, St. Augustine, April 11-14, 1948.

Association in November 1947. I would urge every physician and especially every surgeon to read these articles for what value they may offer in event of future conflict at home or abroad.

Serving with the Seventy-Fourth Field Hospital during the Okinawan campaign, I was fortunate, or perhaps I should say unfortunate, enough to experience war surgery in the rough. Normally a field hospital under canvas has a bed capacity of 400 beds. Ours carried a daily census of 600 patients during the heaviest fighting. It was the first field hospital forward and oftentimes only 1,000 yards behind the fighting front. We, therefore, received casualties relatively soon after being hit. There were but few portable surgical units farther forward than we; so we were called upon to serve in this capacity. We had two such units attached to our hospital staff. As there were few evacuation hospitals on the island, we were forced not only to do life-saving surgery but some definitive surgery as well. We did not, however, keep our casualties longer than twelve days, and the ones who remained that long were the more severely wounded suffering from lesions of the chest and abdomen. We evacuated casualties mostly directly to hospital ships and by air to Guam, Saipan, Tinian, Honolulu and the States.

During the period from April 26 to June 21, 1945 inclusive, only fifty-seven days and nights, our hospital operated at the same location continuously. This period was our heaviest performance. To give a brief summary and breakdown of our casualties during this period, the official data are presented in tables 1 and 2:

TABLE 1.—CLASSIFICATION, MORTALITY AND DISPOSITION

Casualties	
Patients admitted during period	3,731
Medical cases	912
Surgical cases	2,819
Nonbattle casualties	315
Battle casualties	2,504
Mortality	
Deaths	69
From nonbattle casualties	11
From battle casualties	58
Mortality rate, nonbattle casualties	3.45
Mortality rate, battle casualties	2.31
Mortality rate, all admissions	1.85
Disposition	
Patients returned to duty	790
Medical	332
Surgical	458
Evacuated	2,609
Absent without leave	2
Remaining in hospital June 22, 1945	330

TABLE 2.—SURGICAL SERVICE

Penetrating wounds of abdomen	
Celiotomy with no visceral damage found	20
Perforations of intestine	45
Rupture of spleen with splenectomy	10
Bladder injuries	8
Liver damage	3
Kidney damage	3
Stomach damage	5
Total	94
Chest wounds	
Sucking wounds	48
Nonsucking wounds	92
Diaphragm wounds	9
Combination thoraco-abdominal wounds	22
Total	171
Extremity wounds*	
Compound fracture, humerus	65
Compound fracture, femur	62
Compound fracture other than humerus or femur	393
Total	518
Amputations**	
Arms	10
Hands	3
Fingers	8
Thighs	6
Legs	10
Legs, bilateral	1
Legs and arms (basket)	1
Total	39
Life-saving tracheotomy procedures	8
Burns***	
Severe burns	18
Minor burns	30
Total	48
Maxillofacial and head injuries, which included penetrating wounds of the skull, fractures, lacerations, contusions, abrasions and massive soft tissue damage	125
Eye injuries	
Enucleations	15
Other injuries involving major eye surgery	10
Total	25
Appendectomies****	8
Debridements	
Major	995
Minor	385
Total	1,791

*Penetrating wounds of the chest with compound fracture of the humerus, 9, femur, 6, other than humerus or femur, 16. Penetrating wounds of the abdomen with compound fracture of the humerus, 5, femur, 3, other than humerus or femur, 9.

** Of the 28 major amputations, 10 were performed because of gangrene. In 8 of the 10 gas gangrene was present, with 1 death resulting. Penetrating wounds of the chest with amputation of an arm or leg, 16; penetrating wounds of the abdomen with amputation of an arm or leg, 7.

*** These included burns as the result of fire, steam and phosphorus. The penetrating phosphorus burns were the hardest to cope with (removal, copper sulfate solution and dressings).

**** Among the patients subjected to appendectomy was Maj. Gen. Archibald Arnold, Commanding Officer of the Seventh Division Infantry.

With due consideration of the number, type and severity of casualties, transportation facilities, the terrain over which it was necessary to travel with the injured from the front, and the environment in which we operated, we were indeed proud of our record during this period of heaviest fighting. Many, many more casualties were handled before hostilities ceased. As I recall, the number exceeded 6,000. Soon after hostilities ceased, naturally the surgical cases became almost nil and medical cases soared to keep the hospital completely filled until a typhoon deactivated the unit.

What did we learn or what did we refresh our memories with that would be of benefit in future conflict as well as being applicable to our peacetime, home town surgery? In my opinion the summary would be as follows:

Get the most competent surgeons as near the injured persons as practically possible. The initial surgical judgment and skill are the keynotes to saving of life and salvaging of body for the best possible future function.

Physically handle the injured as carefully and as gently as possible, particularly in case of severe fracture.

Combat shock heroically before, during and afterwards, and especially be on the alert for blast injuries when no visible signs are evident.

Make intelligent use, without waste, of blood, plasma, oxygen and fluids, and freedom from exposure.

Resort to such careful and gentle and precision surgery as is practically possible with the best anesthetic available, particularly for positive pressure anesthesia in chest cases and diaphragm injuries.

Carefully and thoughtfully employ debridement of devitalized tissue, saving as much of the healthy tissue as possible without jeopardizing the safety of the patient or the adjacent tissues, thus removing a big source for development of gas bacillus infection.

Carefully and thoughtfully survey and evaluate the blood supply to tissues before they are needlessly sacrificed.

Observe closely for arteriovenous fistulas in massive tissue damage.

Procrastinate before unnecessary amputations are performed.

Detect and correct sucking wounds of the chest as soon as possible.

Use the best judgment possible in evaluating penetrating wounds of the abdomen with reference to hemorrhage and viscus damage.

Carry out frequent aspirations of hemothorax. If hemorrhage persists, it is usually not the lung bleeding. The hilus, intercostal vessels or internal mammillary vessels are usually the source.

Plasma, blood, fluids and vaseline gauze with fluff pressure dressings are still the best for burns with close check on the hematocrit level.

Replacement therapy such as blood, plasma, fluids and oxygen, bacteriostatic aids such as penicillin and sulfonamides, bactericidal measures such as iodine, alcohol and merthiolate, prophylactics such as tetanus toxoid and gas bacillus serum, all are helpful adjuvants, but they are not a panacea for poor surgery and faulty surgical judgment. Good surgery is still the predominant factor in the cure of injury and surgical disease.

Do not lose sight of the value of morale in surgical patients. The will, determination and effort on the patient's part to live and recover completely are major items in so doing. Every effort should be exhausted in building and keeping up morale. This need was especially exhibited to me during my combat experience and surely it is applicable and appropriate to peacetime and home town surgery as well. Early ambulation helps the morale of a patient as much as it helps to prevent thrombophlebitis, phlebothrombosis, embolus, atelectasis, pneumonia or acute peripheral collapse and it aids in tissue healing as well.

The value of nursing care was emphasized in war surgery, and, I might say, nursing care by women. Not enough credit or praise has been given the war nurse who experienced combat. I know that many soldiers were saved who would have died had it not been for the war nurses who attended them. The softness of their voices, the gentleness of their hands and the consoling words they uttered to seriously injured soldiers cannot be underestimated for the value rendered. If we could have had nurses during the worst of the campaign, I am convinced we could have lowered the mortality rate still more. The value of a well trained nurse to a surgical patient is too well established. Combat experience only emphasized this value.

It is most amazing how much punishment, deprivation, exposure and loss of life's substance

a sound, healthy human being with a high morale can withstand and not die. This fact was most impressive in war surgery. In peacetime home town surgery, therefore, why not pursue every effort to prepare surgical patients preoperatively the best that is practically possible in order that they may better withstand the additional damage, danger and punishment of the surgeon's knife?

Even though we may have excellent surgical adjuncts at our finger tips, in the present and the future as well as the past, be it in war or in peace, the value of good surgery to the surgical patient has no peer.

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DISCUSSION

Dr. J. Rocher Chappell, Orlando: Many civilian surgeons, when first confronted with surgery in the combat zone, were appalled with the conditions under which it had to be done and flatly stated that good surgery under such conditions was impossible. Dr. Roberts, by means of his excellent motion picture and his statistical review of casualties treated in the Seventy-Fourth Field Hospital, shows this assumption to be untrue. A mortality rate of 1.85 for over 3,700 admissions is one to be extremely proud of and compares most favorably with mortality tables in the best equipped and ideally situated civilian hospitals.

Military surgery should not be regarded as a crude departure from accepted surgical standards but as a development of the science to carry out a specialized and highly significant mission. It is erroneous to assume that the surgery of war is entirely molded by the concession to the need for haste and confusion for caring for an overwhelming number of patients.

The facilities for surgery are determined by the geographic development of a military force, and the phases of surgical management must conform with military echelons. In the combat zone surgery must, of necessity, consist largely of first aid measures such as controlling hemorrhage, splinting, dressings, instituting resuscitation and initiation of chemotherapy. At this point initial surgery must also be carried out, such as completion of resuscitation, surgery to eradicate infection and debridements, and emergency surgery. Surgery in the zone of communications consists largely of reparative measures, and in the zone of interior it is reconstructive and rehabilitative.

During my tour of duty overseas, I was privileged to see casualties in the zone of communications and in the combat zone, several months being spent in the same area which Dr. Roberts has so graphically shown us. From this experience there are a few comments I should like to make:

First, it is fervently hoped that before the next world war takes place a satisfactory substitute for plaster of paris will have been discovered, especially one that can be used in the tropics. Casualties received from the front on their way home, in plaster casts, were invariably in bad shape. The majority of the casts were broken because of the long time required to harden in the tropical climate, necessitating realignment of fractures and new casts before they continued their journey.

Second, while I am satisfied that the guillotine type of amputations we did was the best suited for military surgery, there were complications for which we always had to be on the alert. During the Philippine campaign, we received a good many amputees and did the initial dressing of them, many as late as seven days after amputation. On removal of the packing from the stump of 2 of these patients, pulmonary emboli occurred almost immediately. From then on, it was our practice to do a high femoral vein ligation before disturbing the dressing. Occasionally, we would find the vein occluded high in the leg, and it would be necessary to do an abdominal ligation.

Third, I am satisfied a few unnecessary amputations were done, particularly of the lower extremities, as a result of high velocity wounds causing what we spoke of as segmental vasospasm or concussion of the extremity. In these cases a typical picture of ischemia of the extremity with an absence of demonstrable peripheral circulation was present, and simple debridement with wide incision of the fascial planes gave rapid relief. The peripheral circulation was very stubborn about returning to normal without debridement, and I am certain that a number of these cases amputation was performed unnecessarily.

Fourth, regarding anesthesia, I am sure that a great many civilian surgeons like myself first used trained M.D. anesthetists in the services and I am satisfied that the contribution of these anesthetists to the better care of military casualties will rank alongside that of chemotherapy, penicillin and whole blood. I was one of those fortunate enough to have a trained M.D. anesthetist with me in this country and overseas and I was so pleased with their work that upon my return to civilian life, the securing of one for our hospital became my number one project.

Fifth, we have read and heard a great deal about replacement therapy, the use of intravenous fluids, plasma and the like, but in the treatment of the severely wounded and badly shocked patient there is no substitute for whole blood. We frequently gave whole blood to soldiers on Okinawa within forty-eight hours after it had been taken from donors in the states. This blood was truly life-saving in many, many instances. I have been asked on several occasions what, in my opinion, was the greatest life-saving measure we used in the treatment of the wounded. My answer was and will be—blood—whole blood.

This picture Dr. Roberts has shown depicts graphically the conditions under which we worked in the Pacific. It was made under trying circumstances and difficult conditions. He is to be congratulated on its thoroughness and its excellent technic.

Dr. Don C. Robertson, Orlando: I appreciate the opportunity to say a few words regarding this most interesting and unusual contribution to surgery of World War II. It is interesting and unusual because to my knowledge it is the first and only motion picture taken by a medical officer of war surgery in a field hospital near the front line. I would call particular attention to the large number of casualties cared for in a period of two months with a record low in mortality. Dr. Roberts and his group richly deserved the official commendation from the War Department for this excellent record. The short interval of time elapsing from injury to admission to their field hospital was undoubtedly in their favor as regards low mortality and morbidity. I would, however, prefer to believe that the chief factors concerned were primarily a highly organized efficient and skillful group from corps men and nurse to surgeon.

Dr. Roberts asked me to make a few remarks regarding the care of these casualties after evacuation to the named general hospitals in the United States because it was in these hospitals that the final definitive surgery was completed and they were either returned to duty or separated from the service. I was stationed at Schick General Hospital, which was named after Lt. Schick, the first medical officer killed in this war. The bed capacity was 3,000, and this hospital was designated as a specialty center for general surgery and orthopedic surgery. The majority of casualties reached there in from one to six weeks and for the most part were in excellent condition considering the nature of their wounds. In a three year period, however, 12,480 surgical patients

were admitted, and of this number 9,735 were operated upon. There were 3 operative deaths, resulting in a surgical mortality of .03 per cent.

Time will not permit even an enumeration of the multiple problems with which we were confronted. Only brief reference will therefore be made to three types of cases which comprised a large portion of our work.

There was a rather large number of very extensive compound comminuted fractures which in many cases required six to fourteen months of treatment. This consisted chiefly of measures to clear up the infected wounds, removal of sequestra, removal of foreign bodies, multiple stage skin grafting, and revision of wounds before final definitive reconstructive bone and tendon repair could be effected. A fairly good-sized group of extensive postoperative and traumatic ventral hernias from other theaters of war presented problems of closure, often necessitating the use of the entire fascia lata from one thigh. On the whole, very gratifying results were obtained in this group.

The colostomy cases numbered 72, and in 64 of these there was closure following crushing of the spur by means of the intraperitoneal method. In this group there was 1 death from pneumonia, 1 recurrence, 2 deep and 4 superficial wound infections. None closed spontaneously following adequate crushing of the spur. Difficulties with these colostomies were conspicuous by their absence.

We saw so many patients returned to us who had received multiple perforations and transections of the large and small bowel that most of us got the impression that it took more than a full measure of machine gun bullets or shell fragments in the abdomen to kill the American soldier. But you know as well as I do that these boys lived because of the initial skillful surgery and care that you saw them receive today up front.

DR. ROBERTS, CONCLUDING: I appreciate the discussions by Dr. Chappell and Dr. Robertson and also appreciate Dr. Spicer coming to the front and giving our good boys a hand. Those medical corps men who were our medical nurses did a wonderful job.

Again I want to thank anyone who sent blood overseas to us when it was so needed.

My two conclusions are: (1) that the fellows who start these wars do not fight them, and (2) the fellows who fight them, do not start them.

Chronic Ulceration of Lower Leg Treated by Excision and Skin Grafting

FREDERICK HARDY BOWEN, M.D.
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There is some opinion among physicians that many ulcers of the leg are incurable and that patients with these ulcers are annoying chronic invalids. To controvert this view, I am presenting 3 cases in which ulcers of the leg have been cured by excision and skin grafting. In 2 of these cases the ulcer has remained healed for over a year and in the third case for seven months.

REPORT OF CASES

Case 1.—S. J., a 24 year old Negro man, was admitted to Brewster Hospital on Feb. 18, 1947, complaining of an extensive ulcer of the lower portion of the right leg of twenty-eight months' duration. Twenty-eight months before admission, he had sustained burns of both lower extremities, and the left leg had healed without complication. The right leg had healed partially, but a persistent unhealed area remained above the malleoli. An unsuccessful split thickness skin graft was applied to this area in another community in 1945.

On physicial examination, the patient was noted to be a well developed and nourished man. The blood pressure was 120 systolic and 80 diastolic. Moderate varicose veins were observed over the right lower extremity, and there was a large ulcer located approximately 3 inches above the malleoli which almost completely girdled the leg. This ulcer was narrow over the tibia and wider on either side as it extended backward; it measured 2 inches over the tibia and 3½ inches on either side. Extensive depigmentation and much hard scar tissue surrounded the ulcer, but the ulcerated area itself was moderately clean. Moderate swelling of the foot was present distal to the ulcer; the right lower extremity perspired excessively as compared with the left and was slightly cooler than the left. The patient limped when he walked, due to the painful ulcer.

The red blood cell count was 4,990,000, and the hemoglobin was 14.45 Gm.; the white blood cell count was 6,850. The differential count was 7 per cent eosinophils, 3 per cent stab forms, 43 per cent polymorphonuclear leukocytes, 46 per cent lymphocytes and 1 per cent monocytes. The urine showed a specific gravity of 1.018 with a trace of albumin; 20 to 25 white blood cells per high power field and mucous threads were noted in the urine. Urinalysis done at a later date showed a faint trace of albumin with 1 to 3 white blood cells per high power field still remaining. The blood Kahn test gave negative results.

Stereoscopic roentgenograms of the chest showed the lungs to be clear. Roentgen examination a month before admission was reported as follows: "X-ray examination of the lower two-thirds of the right leg reveals irregular thickening of the articular cortex of the fibula. This reaches a maximum of about 9 mm. at approximately the midpoint of the fibula or 21 cm. above the ankle joint. It is irregularly thickened from this point downward to a point just above the ankle joint proper. The cortex of the tibia is also thickened in the corresponding area along its anterior and medial aspects. The thickening of the tibia is much more uniform than that of the fibula. There is no evidence of recent new bone formation or sequestra. X-ray Opinion: There is evidence of chronic reaction of both bones to irritation, but most of this can be explained on physical bases. There is no definite evidence of active bone infection."

On the day following admission, under local anesthesia, ligation of the right saphenous vein was done at the saphenofemoral junction and at a point 3 inches above the knee. The patient was then anesthetized, and the ulcer was excised down to and including the deep fascia so

Read before the Florida Medical Association, Seventy-Fourth Annual Meeting, April 11-14, 1948.

that the tendons were clearly exposed. The veins opening into the ulcerated area were ligated, the resulting defect was packed open with vaseline gauze, and a pressure dressing was applied. An ace bandage was applied from the toes to the groin. Ten days following admission, a right lumbar sympathetic block was done with novestoil; 2½ cc. of novestoil was injected through each port. The dressing was changed frequently, and hypertonic saline compresses were applied to the ulcerated area. The patient was given penicillin for eleven days following excision of the ulcer.

In preparing the leg for skin grafting, acetic acid compresses were used in combating an infection which was characterized by greenish yellow, sweet-smelling pus and was probably due to a Bacillus pyocyaneus infection. Chlorophyll ointment was also applied. Twenty days after admission, 125 pinch grafts were removed from the left thigh and applied to the granulating area where the ulcer had been located. These grafts took readily, and the ulcer was healed eighteen days after they were applied. When the ulcer was almost healed, the dressing was removed completely, and 2 per cent gentian violet solution was applied to the area until healing was complete. The patient was discharged on March 29 after a hospital stay of thirty-nine days.

It was noted three months after discharge that the grafted area was firmly healed. The area between the grafts had filled in so that it was smooth. The patient had worn an ace bandage continuously from the time of his discharge from the hospital until he was seen at the time of the three months' check-up. He was instructed to reduce the time the bandage was worn gradually and eventually to discard it.

Case 2.—L. B., a 57 year old Negro woman, was admitted to Brewster Hospital on Feb. 2, 1947, complaining of a chronic ulcer of the lower part of the left leg of ten to fourteen years' duration. The patient had had varicose veins for the past four years. She had had syphilis for a questionable number of years, but her reaction to the blood Kahn test was negative on admission and had been negative for at least six months, and it was thought that she had received adequate treatment for syphilis. She was admitted to the hospital for treatment of the ulcer.

On physicial examination, the patient was noted to be a well developed and nourished woman who was most apprehensive. The teeth were in very foul condition, and numerous cavities were noted. The blood pressure was 170 systolic and 90 diastolic, and the brachial vessels were palpable and seemed thickened. Abdominal and pelvic examinations gave negative results. An ulcer measuring 2½ by 3 inches was present over the lower anterior surface of the lower portion of the left leg. The ulcer was surrounded by an indurated area, and a zone of depigmented scar tissue extended upward from the ulcer. The foot showed a brawny chronic lymphedema, which was especially marked on the medial side of the ankle. Small varicosities were noted in the left thigh. The deep femoral venous circulation was patent, and the communicating veins were competent.

Roentgen examination was as follows: "X-ray examination covering the left leg from just below the knee downward to include the ankle and part of the foot shows at least two distinct processes present in the bones of the leg. In the area 5 to 11 cm. above the ankle joint on the anterior and medial aspect of the tibia, the bone is markedly altered by thickening of the cortex up to a maximum of 2 cm., roughening of the surface and reduction of the thickness of the medullary cavities. In addition to the above localized lesion, there is a generalized increased thickness of the cortex of both tibia and fibula. Opinion: There are two distinct bone lesions in the left leg. The generalized condition is probably luetic osteitis and the localized lesion on an osteomyelitic basis."

Urinalysis gave negative results. The red blood cell count was 4,120,000, and the hemoglobin was 12.62 Gm. The differential count was 46 per cent polymorphonuclear leukocytes, 52 per cent lymphocytes and 2 per cent eosinophils. The fasting blood sugar was 143 and the urea nitrogen 16 mg. per hundred cubic centimeters of blood. The blood Kahn test gave negative results on two occasions. Examination of the spinal fluid showed 3 white blood cells per cubic millimeter, and the reaction to the spinal fluid Kahn test was negative. The reading of the spinal fluid colloidal gold test was 22332211. The Wassermann reaction of the diluted fluid was 4 plus in the .4 dilution, 4 plus in the .6 dilution, 4 plus in the .8 dilution and 4 plus in the 1 dilution. The glucose tolerance test was according to the following table:

Blood Sugar		Urine Sugar
Fasting specimen	120 mg.	Neg.
½ hr. after glucose	200 mg.	Neg.
1 hr. after glucose	120 mg.	Neg.
2 hrs. after glucose	133 mg.	Neg.
3 hrs. after glucose	112 mg.	Neg.

The quantitative sugar in a twenty-four hour specimen of urine was 1.1475 Gm. in twenty-four hours. On another twenty-four hour specimen, the quantitative sugar was 1.3322 Gm. On a third quantitative twenty-four hour specimen, the sugar was 1.6157 Gm. It was concluded from these examinations that the patient had cerebrospinal syphilis and mild diabetes, which were probably playing a part in the causation of the ulcer on the leg.

The day following admission to the hospital, with the patient under general anesthesia, the ulcer was excised down to and including the deep fascia. Following this procedure, part of the tibia was exposed, and multiple drill holes were made in the bone with a ⅛ inch drill, placing the drill holes approximately ¼ inch apart. This dissection was done under a tourniquet which was applied for approximately forty-five minutes. The ulcer was covered with vaseline gauze, and a pressure dressing was applied. This was replaced by a continuous warm dressing of salt solution approximately two days after the operation. One week after the excision, a left lumbar sympathetic block with bromsalizol was done. Eight days after the excision of the ulcer, the left saphenous vein was ligated at the saphenofemoral junction just above the knee with the patient under general anesthesia. It was noted at this operation that the femoral lymph nodes were enlarged. Thirty thousand units of penicillin was administered every three hours following the excision of the ulcer, and this treatment was continued. Warm compresses were used in preparing the ulcerated area for skin grafting.

The patient was given aminoids (a protein hydrolysate, ounces 2 in milk three times a day, during her stay in the hospital and she was also given daily a quart of milk, multiple vitamin therapy and ½ ounce of B-Nicoflavin with iron (F.F.) twice daily. She received intensive antisyphilitic therapy with dichlorophenarsine, injections of bismuth subsalicylate and 5,880,000 units of penicillin distributed over a period of eleven days. This was in addition to the penicillin she received before a positive diagnosis of cerebrospinal syphilis was made. In all, 440 mg. of dichlorophenarsine and a total dosage of 10 cc. of bismuth subsalicylate intramuscularly were administered.

Twenty-three days after admission, pinch grafts were applied to part of the ulcer, as all of the granulating area was not healthy enough to receive grafts. A considerable degree of healing followed this procedure, and ten days later pinch grafts were again applied. Almost all of these grafts took, and the ulcer was completely healed in ten days. The patient was discharged from the hospital forty-six days after admission.

At the end of three months, the scar of the ulcer had contracted markedly. The patient had been wearing an improperly applied ace bandage since her discharge from the hospital. At the end of six months, it was

noted that she had edema of the left leg. She stated that this swelling was worse than it had been prior to operation and that the swelling was worse on standing. On examination, it was seen that edema was noticeable from the knee to the ankle, but it did not pit on pressure. The site of the ulcer was well healed and looked healthy. No noticeable varicosities were present. The patient was seen eleven months following discharge from the hospital, and it was noted that the grafted area was smaller than on previous examinations.

Case 3.—S. H., a 56 year old Negro man, was admitted to the Duval County Hospital on Dec. 30, 1946, complaining of an ulcer of the leg of seventeen years' duration. Seventeen years before admission, the patient had dropped a piece of wood on his left foot, scraping some skin from it. He had paid little attention to this injury, but a few days later the foot had become inflamed. This area had gradually become larger and it would heal and re-open at various intervals. His left foot had begun to swell two months before admission. An ulcer had been present on the lower part of the leg for the past seven years without healing. He had not worked for fifteen years because of the leg ulcer. There had been a sore on his penis thirty years previously, which had disappeared in about seven days. He had lived in Georgia until thirty years prior to admission, when he had moved to Florida.

On physical examination, he was a well developed and nourished male. The eyes revealed that the pupils were pin point in size, and the left did not react to light and accommodation; the right reacted slightly to light. An arcus senilis was present, and the patient was completely edentulous. There was an ulcerated area which completely encircled the lower portion of the left leg and measured between 4 and 6 inches across. The left foot was involved by a chronic brawny lymphedema, and palpable femoral lymph nodes were present.

The red blood cell count was 2,600,000. The serum protein was 8.2 Gm. The serum albumin was 2.75 Gm. The globulin was 5.45 Gm., giving an albumin-globulin ratio of .198 to 1. The nonprotein nitrogen was 54 mg. per hundred cubic centimeters. The blood sugar was 80 mg. Urinalysis gave negative results. After the patient had received several transfusions, the red blood cell count was 4,230,000. A phenolsulfonphthalein test, done on Jan. 18, 1947, revealed a value of 6 per cent in the first specimen, 18 per cent in the second specimen and less than 5 per cent in the third specimen. This test was repeated and revealed a value of 10 per cent in the first specimen, 15 per cent in the second specimen and 15 per cent in the third specimen. The specimens were collected at half-hour intervals.

The patient was placed on a high protein, high vitamin diet and was given several transfusions. Several sympathetic blocks were done on the left side. Fifty days after admission, an extensive excision of the ulcer was done. All of the scar tissue was excised down to the tibia anteriorly and to the tendons posteriorly and laterally, and multiple drill holes were made in the tibia down to the marrow cavity. Several days following the operation, the dressing and vaseline gauze were removed, and the wound was cleansed with peroxide. The wound was then redressed, 5 per cent saline compresses were applied continuously, and the dressing was changed daily for several weeks. The wound was dressed with zinc peroxide at times, and this was alternated with dressings of 5 per cent salt solution. Left lumbar sympathetic block with bromsalizol solution was done on March 13. Thirty days following excision, a left saphenous ligation at the saphenofemoral junction was done under local anesthesia. The following day, pinch grafts were removed from the right thigh and applied to the granulating area. A week later, a left lumbar sympathetic block was again done with bromsalizol. After twelve days, skin grafts were again applied to the granulating area. This dressing was removed a week later, and it was found that there was almost a 100 per cent take of these grafts. The area between the grafts gradually filled in, and healing occurred in most of the grafted area, but the left foot continued markedly edematous. There developed a pressure sore at the site where a metal splint had been in contact with the lateral side of the foot. The patient was discharged after a hospital stay of five months.

The pathologic examination of the excised tissue revealed that the specimen consisted of an irregular mass of tissue measuring 18 by 12 by 1½ cm. The surface was ulcerated and had a granulomatous base. The impression was that this was a chronic ulcer of the leg. The patient was given penicillin during most of his five months' stay in the hospital. Following his discharge, an abscess was opened on the left side of the foot. The resulting wound became infected with maggots on several occasions and it seemed to respond fairly well to dressings with chlorophyll ointment. On two occasions, pieces of bone with drill holes in them came out of the ulcerated area on the anterior part of the leg. Dried red blood cells were used at times in dressing the wounds. The maggots were killed with ether at intervals. Compression dressings with sponge rubber and an ace bandage were used at times in dressing the wounds. The patient was seen thirty-three days after his discharge, and it was noted that his foot was enormously swollen and foul-smelling. He had a high fever and emesis, and was re-admitted to the hospital. The temperature on admission was 103 F. He was treated with penicillin and topical applications and was able to leave the hospital after twenty-four days. Seventeen days after his discharge, the ulcer healed. At that time, however, there had developed some ulceration of the tips of the toes, which gradually healed. Five months following discharge from the hospital, the leg was still well healed, and the lymphedema of the foot appeared slightly less.

COMMENT

These 3 cases illustrate the problem of ulcers in the lower part of the leg. The ulcer tends to produce induration and thickening in the fascia, which contracts about the soft tissues like a band, preventing the return of lymph from the foot distal to the ulcer. This condition causes swelling distal to the ulcer, which was a prominent feature of all 3 of these cases.

In patients with ulcers of the leg, syphilis should be ruled out by a careful history and serologic tests. If the patient has ever had syphilis, an examination of the cerebrospinal fluid should be made. In case 2, in spite of the negative blood Kahn reaction, the cerebrospinal fluid Wassermann reaction was positive in two dilutions and indicated the need for further treatment. It is just as important to rule out the presence of diabetes in these cases. In case 2 there was present a mild diabetes in spite of the absence of sugar from the urine, and treatment consisted of small doses of insulin.

Avitaminosis and malnutrition play a part in the causation of these ulcers, and in all of these

cases the patient received vitamins and amino acids by mouth. Anemia is of equal importance and it played a small part in case 2 and a large part in case 3. A careful examination should be made for sickle cell anemia and pernicious anemia. Anemia should be treated by blood transfusions and hematinics. Hypoproteinemia should be treated by transfusions, plasma and amino acids parenterally and by mouth.

Treatment in all 3 cases was excision of the ulcers with subsequent pinch skin grafts. In cases 2 and 3, the bone was drilled to encourage granulations to grow from the drill holes. This measure resulted in sequestration of thin lamina of drilled bone in case 3, an unusual complication. In all of the cases one or more lumbar sympathetic blocks were done, usually with an agent of intermediate duration. The saphenous vein was ligated at the saphenofemoral junction in all of the cases and in the lower part of the thigh in cases 1 and 2. The patients were encouraged to wear ace bandages to support the healed lesion for six months following healing.

SUMMARY

Three cases of chronic ulceration of the lower part of the leg, treated by excision of the ulcer and skin grafting, are presented.

The importance of excising the thickened band of fascia beneath the ulcer is emphasized.

The importance of examining and treating patients with this condition for syphilis and diabetes is pointed out.

The importance of avitaminosis, malnutrition and anemia, as well as hypoproteinemia, is indicated.

It is my belief that almost all chronic ulcerations of the leg can be cured if they are treated intelligently and forcefully.

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DISCUSSION

Dr. David R. Murphey, Jr., Tampa: I have enjoyed Dr. Bowen's excellent presentation and want to congratulate him upon the results he has obtained in the cases presented.

Chronic ulceration of the extremity is a painful, disagreeable and disabling lesion which, if not eradicated, may jeopardize the extremity and at times even threaten life. A majority of these lesions can be successfully and permanently healed if, as pointed out by Dr. Bowen, they are properly and forcefully treated.

There are certain fundamental principles that must be adhered to, if permanent healing is to result:

1. The original etiologic factor must be controlled, or the lesion will recur. Varicose veins must be obliterated, active syphilis treated, or the sugar metabolism controlled, if these are contributory factors in the ulcer.

2. Improvement of the vascular supply to the involved area is essential if immediate and permanent results are to be obtained. If the ulceration has been prolonged, dense scar tissue forms, the contraction of which decreases the blood supply. Likewise, this produces lymphatic stasis. Unless this condition is remedied, an ulcer may be successfully grafted, only to recur when the patient becomes ambulatory or when the wound is subjected to some trivial trauma. Adequate blood supply of the ulcerated area can usually be obtained by excising the scar tissue from the base of the ulcer, as Dr. Bowen has stressed, and must always be done if recurrence is to be minimized. In those cases in which bare bone represents the base, the lesion must be vascularized before definitive therapy is attempted. Vascularization is accomplished by drilling into the marrow cavity multiple small holes and permitting granulations to grow from the vascular marrow. These quickly spread over the base area and produce a vascular bed which can be successfully grafted. Vascular supply obtained in this manner may not be adequate to withstand ordinary trauma. It is my belief that in such cases treatment should consist of a sliding graft of skin and subcutaneous tissue and an immediate free graft of the resulting defect. The healing time is not prolonged by this procedure, and the vascular supply is enhanced in that the transplanted tissue carries its own blood supply. These grafts must always be pedicled toward the source of the blood supply, which in the case of the extremities is proximal. In addition to the increased blood supply obtained in this manner, the lesion is covered by mobile tissues which are less likely to ulcerate when traumatized than is a skin fixed to the bone as occurs when a free graft is applied to such an area.

3. Many of these cases are in the older age group, and in addition to the initiating factor, failure to heal and remain healed after adequate grafting is the result of diminished blood supply to the extremity. When such a condition exists, the chances of successfully eradicating the ulcer are enhanced if this blood supply can be improved. This may be accomplished by injecting the lumbar sympathetic chain with long-acting local anesthetic agents, as employed by Dr. Bowen in the cases he presented. If the inadequacy of the blood supply is great, preliminary sympathectomy may be required.

The small deep graft of Davis, the so-called pinch graft, was the type utilized prior to the development of the various dermatomes. The advantages of these grafts are: (1) they are easy to cut; (2) the percentage of take is high, even in an infected field. The disadvantages are: (1) the donor site is unsightly and cannot be used as a source of skin again; (2) complete healing is prolonged; (3) the epithelium between the grafts is thin and does not withstand trauma as well as thicker grafts. The development of the dermatomes has made it possible for the occasional operator to cut split thickness grafts of various depths with ease. Prior to their introduction, free hand splitting of skin was an art difficult to master and easily lost if not frequently employed. Split thickness grafts, especially the thinner ones (eight to ten one-thousandths of an inch) take as well as pinch grafts. The defect is completely closed at once and healing is rapid. The healed wound is covered by epithelium of sufficient thickness to withstand ordinary trauma. The donor site heals rapidly and can be used again if necessary. For these reasons I believe split thickness grafts are preferable and should be employed in free grafting of large defects, especially those which are infected. If, for various reasons, thicker grafts or tubes are desirable, later the split skin can be removed, and a clean wound is available for further definitive therapy.

Dr. George W. Morse, Pensacola: Dr. Bowen has just presented a most interesting paper on a condition that is fairly often seen. There is of course no standardized treatment for chronic ulcers of the leg, and the numerous medications and therapies offered are evidence of the lack of knowledge regarding the basic problems in-

volved. The rational treatment of these ulcers must be based upon a sound understanding of the physiologic and mechanical processes responsible for and contributing to the ulceration. For years there has seemed to be a general apathy on the part of the medical profession at large in regard to these ulcerations. Most of the patients have drifted for treatment from drugstore to drugstore, from friend to friend and from doctor to doctor. As Dr. Bowen pointed out, once the chronicity of the ulceration has occurred, the period of treatment is long, the hospitalization is expensive, and the treatment is difficult, tiring and discouraging to the surgeon.

Most chronic ulcerations of the leg follow minor trauma in a leg with varicose veins. Since in most instances these veins are secondary to an incompetency of the valves of the internal saphenous and communicating veins, surgical ligation of them will prevent ulceration with its resulting disability. Until physicians on noting varicose veins warn their patients of the need for immediate treatment of them, these ulcerations will continue to appear and reach the chronic stage. I am sure that the best method of treatment of this condition about which Dr. Bowen has talked today is prophylactic—the prevention of the ulcer in the first place. We do not hesitate to warn the female patient with an eroded lacerated cervix that treatment is necessary if a worse condition is to be prevented. Yet we blithely tell a patient that he has a bad varicose vein in his leg without warning him properly of the need for its treatment if he is to prevent a debilitating condition which economically may be far more costly to him. All too frequently we have seen patients in our offices who have had varicosities for years who have been told by their doctor to wear elastic stockings. Except for those who have definite medical contraindications, there is no excuse for this type of advice. They do not correct the condition; they merely act as a truss does in the patient with a rupture. I am sure we all agree that the best treatment is prevention. As Dr. Bowen has just demonstrated to us, once they have occurred, however, the condition is not hopeless and can definitely be cured.

Dr. J. Rocher Chappell, Orlando: It is not customary for the presiding officer to take up any of the small amount of time allotted to the discussion of these papers, but I was so impressed with Dr. Bowen's paper that I consider a few words about it necessary.

I also enjoyed the discussions of Dr. Murphey and Dr. Morse. Dr. Morse stated in his discussion that the ideal way to prevent varicose ulcers of the leg is to cure the varicosities. This, in my opinion, brings up a problem which is still far from solved. I am not and have not been satisfied with the results obtained in my surgery for varicose veins.

Dr. Haden, in his address before the Association yesterday, in speaking of the anemias due to nephritis, stated that the cure for anemia is obviously the cure for the nephritis, but, he asked, "How can you cure the nephritis?" and stated "I don't know."

The problem of curing varicose veins is similar. I have used injection treatment—the high saphenous ligation, the low ligations and the multiple ligations, and many combinations of these.

Recently I have returned to the old-fashioned vein-stripping operation which was in use many years ago and discarded. I ligate the saphenous vein high at the femoral junction and strip it downward, making incisions when the communicating veins are encountered and sometimes stripping the communicating veins as far as possible. This procedure will, I believe, give better results than any I have obtained so far.

I should like to ask Dr. Bowen what method he uses for the treatment of varicose veins.

Dr. F. Gordon King, Jacksonville: I think that the title of this paper may be misleading. To me the important fact brought out by this discussion is that Dr. Bowen's excellent results came from infinite care and work, regarding every minute detail of the patient, and his good results come not from the surgical measures he has carried out as much as from the fact that he has been an excellent doctor rather than a carpenter. To me the particular type of skin graft used, split thickness, pinch graft, sliding graft, or any other form, is not nearly so important as this infinite care and regard for minute details. I personally prefer split thickness grafts. Important points in the treatment center around, first, improving the circulatory status of the leg by control of varicosities with particular attention to ligation of incompetent communicating veins. Simple saphenous ligation often will not suffice and may not even be essential. Secondly, there is removal of the scar tissue constricting band which Dr. Bowen described, and thirdly, maintenance of pressure over the entire surface of the lower part of the leg by ace bandages, or with the Unna boot, which I prefer. This is important since a state of chronic lymphedema has invariably been present. It is necessary to keep dilated lymph vessels collapsed over a long period of time allowing them to regain their normal tone. And finally, there is the most important part of Dr. Bowen's paper relative to general care and attention to the patient as an individual, including careful regard for the nutritional and vitamin status, careful diagnosis and infinite care in other minute details which are so often passed over lightly. Much time may be saved in early ligation of the incompetent communicating veins, without waiting in an attempt to control completely infections which are present. The tissue seems well vaccinated against organisms present, so that little danger exists in early ligation and surgical therapy. In closing I want to compliment Dr. Bowen for being a most excellent doctor to these patients as well as being a fine technical surgeon.

Dr. Edward Jelks, Jacksonville: Since the methods of handling large ulcers of the leg have been so thoroughly covered by the essayist and the discussors, I shall not try to add anything new to the subject of procedure. The chief reason for my being here is to express appreciation to Dr. Bowen for his outstanding aid to the Duval County Hospital in Jacksonville. He has untiringly spent time and talent in an effort to do something for patients with large ulcers of the lower extremities.

In listening to Dr. Bowen relate the history of these cases one must be impressed with the long hospital stay required to carry out the procedure he describes. So, the criticism might be made that economically it is impractical with private patients to follow Dr. Bowen's practices. The expense of thirty to fifty days' hospitalization, however, should hardly be greater than the cost of two to fifteen years of treatment, even in the hands of the patient himself or by a physician in his office.

Unless one has a generous reserve of patience and persistence, it might be unwise for him to undertake the treatment of one of these large chronic ulcers of the leg. To be successful one must follow the practice of Dr. Bowen, which can be well expressed by a definition of genius, "infinite care in taking pains."

Dr. G. C. Ferrante, Tampa: I am not a surgeon, but I should like to emphasize from the medical angle the points Dr. Bowen brought out. The general cardiovascular condition of the patient has to be thought of also. A cardiac condition is disappointing to the surgeon. Most of the patients with ulcer are up in age, usually in their fifties, and would have a certain amount of hypertension or heart condition that slows down circulation. Any open wound will heal best with proper blood supply. Many of the patients are also on the obese side. Obesity, with age, slows down the circulation, or sometimes brings on the ulcer. The bed rest they have while the ulcer is being treated is helpful.

The surgeon should emphasize to patients with an ulcer that in order for him to obtain good results it is necessary for them to lose weight, if they are obese, because it slows down the circulation. They should be advised that when they sit down they should sit with

the legs elevated and that they should sleep with the ankles elevated on two pillows. It is also necessary, even with no advanced signs of cardiac disease, to place these patients on a low sodium diet and to give digitalis to help control pitting edema. There is a good percentage of edema which is due to cardiac disorders. The patients will obtain more permanent results than if they are allowed to gain weight and have a liberal amount of salt in their diet.

Dr. Bowen, concluding: I surely appreciate all of the discussions of my paper. They were in many respects better than the paper. I greatly appreciate Dr. Jelks' kind remarks. I have learned much of what I know about the treatment of chronic ulceration of the legs at the Duval County Hospital on Dr. Jelks' service, where there is a great wealth of material.

Dr. Chappell asked how I treat varicose veins. I treat them by various methods. In general, I determine whether there is incompetency of the valves of the saphenous vein, whether the deep femoral venous circulation is patent, and whether the communicating veins are incompetent, and do a ligation at the saphenofemoral junction and in the lower portion of the thigh. If there are incompetent valves in the lower part of the leg, I ligate where they are incompetent. In 1 or 2 cases I have stripped the saphenous vein when it was large. I think one of the main things about patients with varicose veins is to get them to understand they have a lesion which is hard to cure and to get them to come back at intervals for examination and treatment. I am still using sclerosing solutions, usually injected through the skin. If it is possible, one should get these patients to return every two months for a year and then every six months for the rest of their lives. There are a number of good doctors who have stopped using sclerosing solutions altogether, but I still use them. It is hard to get the patients to come back for periodic examination and treatment.

In 2 of the cases described in this paper the patient did not get back to useful work. Someone asked what I had done for these older patients. The older patients could not be rehabilitated because the ulcer had been present too long. For them I (1) relieved the pain, (2) corrected the cause of hypoproteinemia and anemia, (3) detected syphilis in 2 cases and treated it adequately and (4) in these 2 cases avoided amputation, which would have had a detrimental psychologic effect. These 2 patients are much better able to get around now than if I had done an amputation. Persons over 50 years of age will not usually wear a prosthesis.

I have enjoyed presenting this paper and desire to thank all who presented discussions.

Influenzal Meningitis: Streptomycin Therapy Report of One Case

Daniel F. H. Murphey, M.D.
St. Petersburg

The influenza bacillus is a gram-negative, pleomorphic organism which may be readily visible on direct smear or which may be difficult to demonstrate in the spinal fluid without culture. The uncertainty of demonstrating the causative organism rapidly and the impossibility of differentiating the acute, purulent meningitides clinically have resulted in relatively small groups of cases treated by any one method. One can, however, draw definite conclusions from the literature as to the efficacy of the various therapeutic agents.

The organism may be classified in the laboratory into various types by testing for capsular swelling, using type-specific antiserums. The known types of influenza bacilli are designated A, B, C, D, E, F and G, but there are still others unidentified. Type B Hemophilus influenzae is the causative agent in almost all cases of influenzal meningitis, but therapy with type B specific influenzal antiserum should only be instigated following a positive sensitivity test of the organism in question.

The basic infection from which the meningitis develops is thought to lie in the respiratory tract; the nasopharynx, middle ear and the bronchi have each yielded organisms identical in type to those in the meninges in many of the cases reported. Blood culture is often positive, and the invasion of the blood stream is held to be a step in the involvement of the meninges.

This bacillus, first described in 1893, was isolated from the spinal fluid for the first time in 1899. From that time the mortality remained at practically 100 per cent until recently, especially in children in whom the vast majority of cases occur. Among children of three years of age and under, this disease has a relatively high incidence and was the greatest cause of mortality from meningitis in this age group in a study of fatal cases from 1935 to 1945 according to Hertzog.[1]

The first specific therapeutic agent developed

Read before the Florida Medical Association, Seventy-Fourth Annual Meeting, St. Augustine, April 11-14, 1948.

in an attempt to improve the prognosis in influenzal meningitis was the antiserum of Fothergill, which was administered intrathecally in combination with added complement. The benefits of this therapy were questionable, and the mortality from this disease remained high, 95 per cent or above. With the advent of sulfonamides, particularly the more recent derivatives, and shortly thereafter the development by Alexander[2a] of a type B specific anti-influenzal rabbit serum, there was a significant decrease in the mortality. The mortality rate remained high in the age group below one year, especially in children under seven months of age.

The development of streptomycin and the fact that the many gram-negative bacilli are sensitive to it have led to an increasing use of this antibiotic in the treatment of influenzal meningitis. In one group of 15 cases at the Boston City Hospital,[3] in 10 of which the patient was below the age of one year, only 1 death occurred. Streptomycin alone or in conjunction with other therapeutic agents was used in the treatment of influenzal meningitis in 163 cases collected from the literature with 24 deaths, a mortality rate of 14.7 per cent.[4-10] On the other hand, in a series of 80 collected cases treated by antiserum alone or in conjunction with other therapeutic agents, excluding streptomycin, 27 deaths occurred, a mortality of 33.75 per cent.[11-13]

From these results one concludes that no therapeutic agent now available can be counted on alone. Alexander[2b] believes that streptomycin alone can be used successfully in the less severe cases. She is of the opinion, however, that in the more severe cases, those in which the spinal fluid sugar is below 20 mg. per hundred cubic centimeters and in those patients under seven months of age, streptomycin, antiserum and sulfonamide therapy in combination is the treatment of choice. Judging from reported cases,[14-17] penicillin may occasionally be a valuable addition to the armamentarium in the treatment of this type of meningitis. Alexander[2b] formulated the following schedule of therapy:

1. Streptomycin alone in meningitis of mild or average severity.
2. Streptomycin and sulfonamides in severe meningitis caused by other than type B organisms.
3. Streptomycin, sulfonamide and type B specific rabbit serum in severe cases due to type B H. influenzae.

The fact that occasionally a strain of influenza bacillus proves sensitive to penicillin should be borne in mind. Certainly this agent should be employed in cases in which there is no response to other forms of therapy.

The various therapeutic agents should be given in amounts sufficient to guard against the development of insensitive strains. Alexander, Leidy, Rake and Donovick[5] produced streptomycin-resistant strains by the growth of the bacillus on culture medium containing small amounts of the antibiotic. The following schedule of dosage of the various agents is suggested:

1. Sulfonamides are given in amounts from 1½ to 3 grains per pound of body weight per twenty-four hours, sulfadiazine being the one most frequently employed. The intravenous route of administration may be employed at first, particularly in those cases in which nausea and vomiting are a problem. The change to oral medication may be made as soon as this mode of therapy becomes feasible. The sulfonamides should be continued for at least a period of two weeks after the discontinuation of the other therapeutic agents in order to insure against recurrence.[18] An adequate fluid intake and alkalinization of the urine are advisable in order to reduce the chance of irritation of the kidneys.

2. Type B specific anti-influenzal rabbit serum is administered intravenously only after laboratory verification of specific sensitivity of the offending organism. It goes without saying that the patient should be tested for sensitivity to the proposed serum. The equivalent of 75 to 100 mg. of antibody nitrogen is given in saline solution, 200 to 400 cc. being administered over a period of two to three hours. Further dosage may be given intramuscularly if progress is not satisfactory or if the patient's serum fails to show sufficient antibody titer to produce capsular swelling in the organism in a dilution of 1:10.

3. Streptomycin should be given both intrathecally and parenterally, preferably intramuscularly. The intraspinal dose should not exceed 0.1 Gm. in 5 to 10 cc. of normal saline, this amount replacing a larger amount of withdrawn spinal fluid. In smaller children the initial dose of intrathecal streptomycin may be restricted to 0.025 Gm. and subsequent doses, if needed, increased to 0.05 Gm. A single intraspinal dose[5] or parenteral therapy[10] alone may be sufficient. The general opinion is, however, that at least one intraspinal administration is advisable since

streptomycin does not diffuse into the spinal fluid to a sufficient degree to assure an antibacterial level.

The intramuscular dosage averages between 1 and 3 Gm. per twenty-four hours and is divided into six to eight injections. The daily dose may be calculated on the basis of 0.02 Gm. per pound of body weight per twenty-four hours according to Alexander,[2b] but this is below the amount generally used at present. Paine and Finland[3] reported giving up to 0.075 Gm. per pound of body weight per twenty-four hours to infants and young children. McDermott[19] placed the maximum safe dose at 3 Gm. per day over short periods of time in treatments of one to two weeks' duration.

Intrathecal administration of the antibiotic may be accompanied by local pain with extension into the sacral region and into the posterior areas of the thigh. This may last twenty-four hours, but this tendency may disappear on repeated administration. Intrathecal dosage exceeding 0.1 Gm. may be accompanied or followed shortly by headache, nausea and vomiting, and a greater increase in the intraspinal dose may result in nystagmus, somnolence and stupor with slowed respirations and retention of urine. The drug may have an accumulative effect since it remains in the spinal fluid at an appreciable level for as long as seventy-two hours after administration.[19]

The purer the product used the less is the tendency to toxic reaction, both in regard to intrathecal and parenteral therapy.

The intramuscular administration may result in toxic manifestations of dermatitis similar to that from other chemotherapeutic agents. There may also be joint pains, fever, headache, vomiting, leukopenia and eosinophilia lasting for the duration of the therapy. The urine in a large number of cases in which the antibiotic is administered may show casts and albumin, and in cases in which renal damage is already established, an elevation of the blood urea nitrogen may result. In the latter cases also, retention of the drug may build up the level in the body to the point of the development of other toxic manifestations. The neurologic manifestations of toxicity are:

A. Vestibular dysfunction, characterized by headache and a feeling of heaviness in the head, and a sensation of overshooting on sudden movement. Rotary sensation and nystagmus are usually absent in vestibular dysfunction due to streptomycin.

B. Deafness, which is apparently due to overdosage and which is apt to occur in patients receiving an unusually large dose, in those with pre-existing renal disease and in those receiving repeated intrathecal treatment. Loss of hearing may be temporary or permanent, partial or complete. Discontinuation of the drug is advised on the development of such manifestations, except in those cases in which it is thought that life depends on its continuation.

Penicillin may be used on occasion as a therapeutic agent directed directly against the influenzal bacillus, or as a preventive of secondary infection by streptomycin-resistant organisms. In the cases reported[14-17] in which penicillin was used for the treatment of influenzal meningitis, large doses were used both parenterally and intraspinally. Treatment was continued over a period of seven to twenty-one days depending on the clinical and laboratory findings. The dosages used were as much as 100,000 units per day intraspinally and 1,000,000 units per day intramuscularly. In some cases in which there was no response to smaller doses, the response to an increased dosage was satisfactory.

REPORT OF CASE

A 21 month old Negro child was seen at home on Oct. 19, 1947. There was a history of fever and general malaise of three days' duration. In addition to the pyrexia, irritableness, drowsiness and anorexia developed. There was no nausea nor vomiting, and no other symptoms arose. The child continued to take fluids well.

She was a full term child of normal pregnancy, labor and delivery. Development had been normal, and there had been no illnesses other than an occasional mild infection of the upper part of the respiratory tract. The family history was not contributory.

On physical examination the patient was a well developed and nourished Negro girl of about 2 years of age. She was lethargic, but resisted vigorously and cried loudly when disturbed. She seemed oriented. The neck and back were stiff and resistant to flexion, though there was no opisthotonos. The reflexes were equal and hyperactive. The nose, throat, ears, mouth and chest were normal. The skin and mucous membranes were clear.

The child was admitted to the hospital immediately, and a spinal tap was performed. The spinal fluid was 'ground glass' in appearance. The total cell count was 3,400, of which 90 per cent were polymorphonuclears. The spinal fluid sugar was 50 mg. per hundred cubic centimeters and the protein 79 mg. Smear of the spinal fluid (reported in twelve hours) and culture (reported in forty-eight hours) were positive for H. influenzae. The type was not determined. At the time of the initial puncture, based on the character of the fluid, 25,000 units of penicillin was introduced into the subarachnoid space and 100,000 units started intramuscularly every three hours. In conjunction with the penicillin therapy, sulfadiazine was given orally in dosage of 0.5 Gm. every four hours. This dosage of sulfonamide was continued

throughout the hospital stay and for two weeks following discharge. On October 21, the urine was normal; it showed many red blood cells on October 23, and on October 24 the hematuria had cleared without change in the sulfadiazine dosage. The examination of the blood on October 24 revealed 14,200 white blood cells with 85 per cent polymorphonuclears, red blood cells 3,710,000 and hemoglobin 10 Gm.

The second spinal puncture was performed on October 21, five days after the onset, following the report of the culture. One hundred milligrams of streptomycin was given intrathecally, and administration of 0.3 Gm. intramuscularly every three hours was begun. This specimen of fluid contained 80 mg. of sugar, 30 mg. of protein and 80 white blood cells, of which 60 per cent were polymorphonuclears. The smear was negative for organisms; the culture was reported positive as on the previous examination.

The final spinal puncture was performed on October 27, on the eighth hospital day. The fluid showed the following: sugar, 62 mg., protein, 38 mg., total cell count 15 with 20 per cent polymorphonuclears, and negative smear and culture.

The patient's clinical condition improved from the time of the initial spinal puncture, and the course in the hospital was uneventful. The temperature on admission was 104.6 F. and ranged thereafter between 101 and 102 F. until the discontinuation of the streptomycin on the tenth hospital day, following which time it dropped to a level between 97 and 99 F. and remained there.

The child was discharged from the hospital on October 31, but sulfonamide therapy was continued. Subsequent physical checks at one week, one month, and three months revealed no signs of recurrence nor residual.

SUMMARY

The literature pertaining to influenzal meningitis is briefly reviewed. Therapy is discussed with special reference to streptomycin, and a schedule of dosage of the several therapeutic agents is suggested. The toxic manifestations that may occur following the administration of streptomycin by the various routes are outlined.

The case of a 21 month old Negro girl treated successfully with streptomycin in conjunction with penicillin and sulfadiazine is reported.

It is concluded that no one therapeutic agent now available can be counted on alone to combat H. influenzae meningitis.

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DISCUSSION

DR. COUNCILL C. RUDOLPH, St. Petersburg: Dr. Murphey is to be congratulated on the excellent manner in which the subject has been covered and on his handling of this particular case. As with so many of the meningitides and other diseases carrying high mortality twenty years ago, it is highly pleasing to find that our weapons of today are proving so successful in confining death rates to the lower brackets.

Certainly in the treatment of so serious a disease we are justified in using every therapeutic agent that has been proved of value. Sulfadiazine and type B specific serum have proved of undoubted value, and penicillin has proved of value with some strains. All should be used in cases of severity.

Streptomycin—well, two weeks ago I would have included it among the musts and probably would use it tomorrow if the occasion arose. After Dr. Platou's discussion of its ability to produce streptomycin-resistant strains of influenza bacilli, however, and his belief that too many of his streptomycin-treated patients come back with encephalitic changes which he thought might be streptomycin-produced, I would surely use it only in the more serious cases and then not intrathecally.

DR. JAMES R. BOULWARE, JR., Lakeland: Dr. Murphey has given us an excellent review of the literature on influenzal meningitis. He has discussed the four agents, namely, (1) sulfonamides, (2) type B specific anti-influenzal rabbit serum, (3) streptomycin and (4) penicillin, which may be used in the treatment of influenzal meningitis and has given us a schedule of dosage of these agents.

I want to emphasize a statement he made,—"no one therapeutic agent now available can be counted on alone." Reports can be found of cases showing that patients with

influenzal meningitis have been cured by each of the individual agents, but most of these cases were of the milder type.

As Dr. Murphey said, Alexander believes that streptomycin alone can be used to treat the mild and average case, but that a combination of sulfonamides, serum and streptomycin should be started at once in the treatment of severe cases, that is, those in which the spinal fluid sugar is below 15 mg. per hundred cubic centimeters and in which the patients are babies under seven months of age.

But there are hazards in streptomycin treatment, chiefly, the development or appearance of streptomycin-resistant strains of Hemophilus influenzae during treatment and recurrence of complicating secondary infections due to streptomycin-insensitive organisms, such as streptococcus pneumonia and otitis media.

Dr. Ralph Platou in his talk to the Pediatric Society reported that at Charity Hospital in New Orleans they were having an increased incidence of late encephalitides such as personality changes in patients with influenzal meningitis who had been treated with streptomycin added to the other agents.

Most writers recommend that streptomycin be given intrathecally and intramuscularly. Hoyne and Brown are convinced that intrathecal therapy is not needed in any meningitis, including influenzal meningitis. In a recent (Feb. 28, 1948) article in the Journal of the American Medical Association, they reported a series of 28 cases of influenzal meningitis; 21 of the 26 patients who recovered received no intrathecal therapy. Not only do they believe that intrathecal therapy is not needed, but that recovery is more prompt and complications less when intrathecal therapy is omitted.

In the discussion which followed Dr. Platou's talk he stated that streptomycin should be given intrathecally only in tuberculous meningitis. And moreover, he added that they at Tulane and Charity Hospital believe that it is never necessary to give penicillin intrathecally.

I had a recent case of influenzal meningitis in a 2 year old boy. A cold started November 18, and there was high fever the next day. On the third day he had a stiff neck. His white blood cell count was 16,000 with polymorphonuclears 89 per cent and lymphocytes 11 per cent. The spinal fluid showed 3,500 cells with normal sugar. A smear showed gram-negative pleomorphic bacilli, and a culture was later reported positive for H. influenzae. Penicillin and sulfadiazine were started at once. When the report on the smear was received, streptomycin ⅛ Gm. (125 mg.) was started and was given intramuscularly every three hours. This therapy was continued for six days; culture of the second spinal fluid specimen was then negative. Penicillin and sulfadiazine were continued for four more days. He was discharged cured in ten days, having received no intrathecal therapy.

I congratulate Dr. Murphey on his excellent paper.

Dr. Murphey, concluding: Had I been convinced that we knew all about the treatment of meningitis, particularly influenzal meningitis, and not only that, but also the use of therapeutic agents in general, I think Dr. Platou's discussion would have been quite a blow to me. In reviewing the literature I realized, however, that for some time to come there will be changes in opinion as to just how these should be used and how influenzal meningitis should be treated. Certainly the dangers of various antibiotics have not been fully brought to light, and I believe we will be more cautious in our use of them as time goes on.

ABSTRACTS OF MEDICAL ARTICLES

OBSERVATIONS IN TREATMENT OF HYPERTENSION WITH RICE-FRUIT DIET. By M. Eugene Flipse, M.D., and M. Jay Flipse, M.D. South. M. J. 40:721-728 (Sept.) 1947.

The authors recommend a dietary control of hypertension, a disease which exacts a high rate of mortality among persons over 50 years of age. Although hypertension has been approached with many therapeutic procedures, some of which have had value in certain individual cases, many physicians are skeptical of any treatment of hypertension, the authors point out.

Experimentation with dietary control by low salt and low sodium diets is noted in the literature. The authors found that within a maximum of six weeks a strict rice-fruit routine was effective in controlling the blood pressure in 20, or 62.5 per cent, of 32 cases of essential and renal hypertension in ambulatory private patients. They state that the diet is of benefit in the relief of chronic uremia and edema of great degree when other treatment has failed even though in some cases the blood pressure fails to decline. Ten of 14, or 71.5 per cent, of those patients benefited by a strict routine maintained the improvement when the diet was modified with meats, vegetables and even a small amount of salt.

The authors observe that loss of weight is not a significant factor in the benefits produced by the diet; restriction of water is not necessary; addition of sulfocyanate and other medical treatment is not contraindicated; many failures result from poor cooperation because patients find the diet difficult to follow; and the harmful effects of the diet are primarily those of starvation in patients who for various reasons do not take their full caloric requirements, and in such cases discontinuance of the routine is warranted. Nine cases are reviewed.

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HOSPITAL PROBLEMS
HOW CAN THEY BE SOLVED?

Hospitals today constitute big business. They represent an annual purchasing power of more than a billion dollars. Their raw food bills alone total nearly half a billion annually. The capital investment in their properties reaches huge proportions, and it has been estimated that their accumulated need for new and replacement facilities totals almost four and a half billion dollars. On top of this, hospitals feed one and a half million patients and a million employees daily, operate laundries which compare with those of commercial institutions and in general fill a place in the average community life which is not only big but vital.

That there are great problems in the efficient management of the modern hospital none will deny. Thoughtful people in the medical and hospital world are somewhat divided in their opinions on the challenging and controversial issue of administrative responsibility for control of medical quality in hospitals.

Who are our hospital leaders?

Are the hospital staff and the hospital administration two separate entities or does the word hospital mean the staff and the administration together? Is the hospital a group of people organized to care for the sick and injured, or is it just a workshop for licensed physicians to use in caring for their patients as they see fit?

These and many other thought-provoking questions come to mind when one considers the problems of a modern hospital.

During the summer of 1947, an article appeared in the Woman's Home Companion, entitled "Unnecessary Operations." Although many people do not approve of the article in its entirety, most authorities seem to agree with the main point: Some bad work is done everywhere, in good hospitals as well as bad.

What is the hospital's responsibility in preventing unnecessary operations, and how far can the hospital go in correcting malpractice?

The medical staff should direct all medical activities, but staff members, not wanting to hurt one another's feelings, sometimes will not take the responsibility that they should in these matters. In most hospitals there are members of the staff who are not qualified to do all types of surgery; yet other members hesitate to speak out about their qualifications.

What can the administrator do when a complaint comes to him about the quality of medical care rendered in the hospital? As a practical matter all he can do at the time is to refer the complaint to the medical staff.

The medical profession is a self-policing profession and there is no one else who can police it. A nurse or a lay superintendent has no sure way

to determine what doctor performed an unnecessary operation. Even the courts cannot police it, for they are dependent upon expert testimony. The medical profession is self-policing by virtue of a code of ethics that doctors have imposed upon themselves. There are scalawags among them, but most live according to high standards and try not to deviate therefrom.

It was a group of doctors who began inspecting hospitals and approving or disapproving their standard of work. A similar group began the study of intern and resident training in hospitals and laid down standards for improvement. Likewise, it was a group of physicians who began the study of medical schools and prescribed requisites for their standardization.

What is the role of the administrator?

An outstanding hospital executive recently said: "The first obligation of the hospital trustee, as I see it, is to provide the highest standards of professional care; second, to assure the maintenance of the physical plant, and, third, to obtain the necessary financing." He might have added that what an outstanding hospital administrator should, can and does do, is to stimulate the medical staff to better organize itself. Actually that is included, indirectly, in his first aim.

When the administrative executive is familiar with everything that goes on in the hospital, when he knows of every breach on the part of a doctor, when he takes up such difficulties with the proper authorities on the staff and sees that action is taken, in a word, when he is alert and follows through with his duties, better organization on the part of the staff is apparent and the general quality of the professional work improves.

There are so-called hospitals in this country which are places where individual doctors take their patients, carry out their own procedures and send them home. In hospitals of that kind many abuses are apt to be found. But in the hospital where the doctor is a member of the staff, where there are consultations and pathologic reports, where at the end of the month there is a medical audit, the picture is apt to be much different. The medical staff controls the abuses, and the administration has accomplished its aim by seeing that the medical staff is properly organized.

The question: Will outstanding hospital leadership in the form of well organized medical staffs and alert administrators perpetuate the hospital system free from governmental control and free from policies which originate in Washington? It is our belief that we will. This is our challenge, and we hereby accept it.

THE STATE OF THE NATION'S HEALTH

How bad are health conditions in the United States? The hue and cry for compulsory health insurance raised within the national government and openly espoused by its leaders during the present administration make this question a natural one. Fortunately, the answer is now readily available and clearly set forth after searching scientific investigation.

Probably no great nation in the world has among its white population better health than prevails in the United States. This is the initial conclusion in the recent study[1] made by the Brookings Institution, commented upon editorially last month. While a few small homogeneous countries, such as New Zealand with respect to its white population, are slightly ahead of the United States as a whole, certain states in this country with larger populations equal them.

Furthermore, under its voluntary system of medical care the United States has made greater progress in the application of medical and sanitary science than any other country. This progress is now reflected in low mortality and morbidity rates of infectious diseases and in increased life expectancy. There is every reason to believe, the report continues, that these trends will continue unabated under the present system.

There is no evidence to indicate that the materially poorer health among the nonwhite population in this country is primarily or even mainly due to inadequacy of medical care. Health problems of necessity involve economic, cultural, and social racial differences and interracial relations. The improvement of health is by no means solely a matter of medical care.

The advances in health among both the white and nonwhite populations that have been made in the United States in the last four decades do not suggest basic defects in the American system. So conclude the Brookings researchers. Somehow, the health of the country goes right on improving; impartial research fails to find that medical progress is faltering in any way.

Not without defects of course, the present free system is nevertheless the mainspring of a going concern. It succeeds. It progresses. It is indeed, in the words of a lay editor, 'a living fact, in contravention of the hopeful visions and unfulfillable promises of the socialist planners.'

1. Bachman, George W., and Meriam, Lewis: The Issue of Compulsory Health Insurance, Washington, D. C., The Brookings Institution, 1948. This is the second in a series of editorials commenting on the Brookings Report.

Indisputably, the bureaucrats in Washington know a good thing when they see it. But they think they could improve on it—by regimentation of the profession and at public expense running into astronomic figures. Paradoxically, they would make it better by means that would undoubtedly make it worse.

Is it not high time for the individual physician in every state throughout the nation to take his cue? It would seem altogether appropriate that in his everyday contacts he lose no opportunity to present the true case of his profession and acquaint the laity with the remarkable attainments of a voluntary medical system which has given this country world supremacy and leadership in health.

TRAFFIC ACCIDENT "DEATH SEAT"

With the higher than predicted traffic accident toll of the Fourth of July weekend still vivid in retrospect, the Labor Day weekend with a probable toll equally high is now at hand. In the light of recently compiled statistics, the passenger in the front seat has the most likely rendezvous with death.

It appears that guest passengers in the front seat are injured three times as often as the driver. In fact, the driver, protected by the steering wheel, occupies the safest seat in the car. In a study of accident victims coming under his observation, Dr. Claire L. Straith,[1] chief of the plastic surgery division, Harper Hospital, Detroit, found that about 70 per cent of 50 consecutive patients with facial injuries from automobile accidents were young women and girls occupying the "death seat," the front seat next to the driver where the occupant is in an unprotected position in case of sudden stops. The Detroit study showed that more than half of the front seat passengers involved in automobile accidents sustained injuries of the head, including facial cuts and damage to the teeth, chin, nose, cheeks, ears, forehead and skull.

Driver's "bad luck" appears to be exploded as something of a myth by accident records of the Detroit Police Department. In 219 accidents involving more than one occupant, 260 passengers but no drivers were injured.

Personality characteristics and emotional reaction behind the wheel rather than bad luck are an important cause of traffic accidents according to research reported by the Connecticut Department of Motor Vehicles. This report was based on examination of 186 licensed motor vehicle operators, of whom half were classified as bad drivers and half had no record of traffic violation in 100,000 miles of driving.

Particularly significant was the finding that operators without a record of accidents had better driving attitudes in regard to obedience to the laws, courtesy of the road, decisions of the courts and what causes an accident. Those charged with repeated violations attributed freedom from an accident more to good luck than to the driver's ability.

Such intelligent and scientific studies of the causes of accidents and the practical application of the findings are a constructive approach to the reduction of the death toll on highways. Too, they should have influence on automobile designing. They might well lead to elimination or addition of details that will make the occupant of the "death seat" less vulnerable to injury.

COSTS OF MEDICAL CARE VERSUS COSTS OF LIVING

Inflation is an ancient goldbrick. Very much in the ascendancy of late years in the consumer's pocketbook as well as in the news, this fraud of the ages bodes only ill, as history attests. It is natural then that physicians should ask if the general cost of living has gone up faster or slower than a particular fee or service rate charged by them, such as an office call.

The gratifying answer is that the cost of living has risen more rapidly than the fees charged by physicians for medical services. Recently off the press is a new study entitled "Comparative Increases in the Costs of Medical Care and in the Costs of Living" by Frank G. Dickinson, Ph.D., economist and statistician, director of the Bureau of Medical Economics Research of the American Medical Association. This study confirms one made by this author earlier this year entitled "Is Medical Care Expensive?"

Dr. Dickinson found that the quantity of medical care received by the American people was at least two thirds more in 1946 than in 1939. He observed that it probably has increased much faster than the number of physicians has increased. This upward trend doubtless reflects the increasing use of technical assistants by physicians. The quantity of physicians' services, one of the medical care items, he estimated as approximately one-half greater in 1946 than in the

1. Straith, C. L.: Guest Passenger Injuries, J. A. M. A. 137:348-351 (May 22) 1948.

base period 1935-1939, but the number of physicians was only one-seventh greater.

In his earlier study Dr. Dickinson stated that medical care items as a whole cost $5,600,000,000 in 1946, representing but 3.9 per cent of the total personal consumer expenditures of the people of this country, compared with 4.3 per cent in 1940. Too, in 1946 physicians received only 26 per cent of all the dollars spent for medical care as compared with 31 per cent in the base period, 1935-1939, and 32 per cent in 1929. On the other hand, the expenditure for drugs in 1946 had risen to 24 per cent of all dollars spent for medical care as compared with only 21 per cent in the base period, 1935-1939, and 20 per cent in 1929. This increase writes into the recent history of medical economics the story of the wonder drugs.

That the American people have been fortunate in that the costs of keeping well have not risen as rapidly as the cost of living is clearly indicated in these studies. Too, it appears that they are getting more for their money, they get well quicker, they live and earn longer. Life expectancy at birth rose from 59 years in 1929 to 67 years in 1947. In the author's opinion the type of medical care given now differs as much from the type given in 1929 as the passenger automobile currently in use differs from a 1929 model.

PSYCHIATRY'S WARTIME LESSONS APPLIED TO PEACETIME PROBLEMS

Why the lessons learned at tremendous cost in one global conflict were not applied to advantage in the next war only a quarter of a century later poses a $64 question for the psychiatrist to answer. Certainly he can testify to this failure. At the beginning of World War II the psychiatric knowledge gained in World War I indicated plainly enough that for every four men wounded there would be one psychiatric casualty. Nevertheless, no preparations were made to care for this fifth man.

The struggle of psychiatry during the early years of this war for recognition as a specialty dealing with the prevention, diagnosis and treatment of mental ill health and the eventual attainment of an even footing with Army medicine and surgery are recorded in a recently published book, appropriately entitled "Psychiatry in a Troubled World."* This dramatic and compassionate story of thousands of Army psychiatric casualties, their treatment and cure, brings to light many lessons learned at great cost which are applicable in peacetime practice as well as in another emergency.

The author of this timely volume is Dr. William Claire Menninger of the Menninger Foundation, who served as chief consultant in neuropsychiatry to the Surgeon General of the Army during the war. It was he who refused to let the Army tick off the emotional casualties as cowards and malingerers. Discarding the damning term "psychoneurotic" was his idea. He introduced the program of training all officers to recognize the first signs of neurosis-silence, belligerence and dullness. He estimates that at least 90 per cent of the servicemen came through the war without serious personality changes. And of the remainder, the so-called war neuroses and combat fatigue cases represented only a small part.

Nevertheless, Dr. Menninger admits the existence of "a large war-induced or war aggravated psychologic problem" and he offers wise advice on everyday problems of adjusting to life's demands. With sympathetic candor, he urges not the handicapped veteran alone but any other person with emotional troubles to face the reality of his situation "with all its unpleasant attendants." It is not enough to know that there is nothing physically wrong and that he is "just nervous." Within the limits of his intellectual capacity he must learn what is wrong and why.

Drawing further upon his war experiences, this eminent psychiatrist suggests eight other factors that should help solve the problems of civilian life in these days of heavy world and personal burdens. In addition to recognition of the existence of a struggle between the personality and the environment, he names a job with a purpose; teamwork; leadership in some capacity; intellectual growth through cultivation of new ideas and learning new things; promotion of the individual, the family and the city, state and nation; recreation; religion; and new awareness of emotional conflicts and of the occurrence of "operational fatigue" in civilian as well as military life.

*Psychiatry in a Troubled World. By William Claire Menninger, M.D. Pp. 636. New York: The Macmillan Company, 1948.

REPORT OF DELEGATES TO A. M. A. CONVENTION*

The Ninety-Seventh Annual Session of the American Medical Association was held in Chicago, June 21-25, 1948. The House of Delegates met on Monday, June 21, at 10 a.m. and continued its deliberations daily until late in the afternoon of Thursday, June 24, one of the longest meetings of the House in history.

Despite the heat and humidity of a typical Chicago summer, there was a total registration of 11,963 Fellows of the Association. These, together with guests and large numbers of the members' families, constituted a very noticeable addition to the city's population, which resulted in considerable overcrowding of the usual facilities in and surrounding the hotels.

This Session of the Association might be said to be the first to take place in the so-called new atomic era. The nearly mile long Navy pier was filled with commercial and scientific exhibits, and the interested visitors were treated to a variety of televised operations from nearby hospitals, a series of exhibits on atomic energy, and demonstrations by amputees showing the great advances in the art and science of rehabilitation.

The first order of business of the House of Delegates following the seating of the delegates was the election of the recipient of the Distinguished Service Award. The names of Dr. Isaac Abt of Chicago, Dr. Alfred Blalock of Baltimore and Dr. Seale Harris of Birmingham were placed in nomination. By secret ballot Dr. Abt received 99 votes, Dr. Blalock 26 and Dr. Harris 34.

The House was next addressed by the Speaker, Dr. R. W. Fouts. The address of the President of the American Medical Association, Dr. Edward L. Bortz, followed. I respectfully recommend that the address of Dr. Bortz, as published in the July 3 issue of the Journal of the American Medical Association, be read by every member of the Florida Medical Association.

The Chairman of the Board of Trustees, Dr. E. L. Henderson, next reported on the activities of and cooperation between the American Medical Association and the Honorable J. A. Krug, Secretary of the Interior, regarding medical service in Alaska and our oceanic possessions, together with a special investigation of the conditions of health and sanitation among the Navajo Indians. Dr. Henderson gave a second report on the status of the World Medical Association and stated that among the objectives of this association is an evaluation of the status of the physician, the standards of medical education, the methods of rating specialists, and fraudulent advertising and cult practice. It is also studying war crimes and the best methods of preventing recurrences. Study is being given the problem of displaced physicians, graduate medical education, the various programs of social security, and the preparation of an international code of ethics.

The reports of the Committee to Study Conditions of General Practice and the Committee on Nursing Problems were also presented by Dr. Henderson. One of the findings of the Committee on General Practice was that the hospital staff "should be the sole deciding body as to who may practice medicine in the hospital either as a staff member or as having hospital privileges, since the certifying Boards pass only on the ability of a man to perform work in his specialty."

The Committee on Nursing Problems recommended that in order to supplement the present and future grave shortage of nurses two main classes of nurses be prepared through different methods of training to assist in taking care of the sick; first, the "professional nurses" who are to consist of (1) nurse educators and (2) clinical nurses; and second, the "trained practical nurse." The main difference between the two is that the "trained practical nurse" is schooled primarily to take care of the sick in the hospital room and the duration of training is to be considerably less than that of the "professional nurse," consisting of three months training in theory and nine months in practical nursing. If such a plan can be put into action, it is thought that the 400,000 nurses who will be needed to care for the ill in this country in 1949 can be furnished. Action by the House of Delegates on this subject will be referred to later in this report. The Department of Labor statistics indicate that about 550,000 nurses will be needed in 1960. To meet this anticipated need about 50,000 nurses must be graduated each year between 1951 and 1960, whereas the largest number of nurses ever graduated was 44,700 in 1947.

The House of Delegates was addressed by Rear Admiral C. A. Swanson, the Surgeon General of the United States Navy, who discussed

*The Proceedings of the House of Delegates are published in full in the July 3, 10 and 17 issues of the Journal of the American Medical Association.

Read and approved at a meeting of the Board of Governors, Jacksonville, July 25, 1948.

the possibility of drafting doctors into the armed services and made a plea for the assistance of the Association in adequately staffing the medical departments of the armed forces.

The most impressive address of the entire meting of the House was that of Dr. Paul R. Hawley, Chief Executive Officer of the Blue Cross and Blue Shield. Dr. Hawley presented his address in Executive Session and called attention in no uncertain words to the great dangers which are increasingly threatening the system of free medical enterprise in this country. It behooves every physician in America to obtain a copy of this address and to study most carefully its contents and recommendations.

Although time will not permit a detailed account of the voluminous Proceedings of the House of Delegates, it is hoped that every member of the Florida Medical Association will carefully review the deliberations and decisions of that body. The functioning of the House of Delegates represented a great tribute to the system of organization, the stability and the wide scope of the American Medical Association. The House very definitely increased in stature as a governing body in the taking of a firm stand upon many controversial issues, some of which are worthy of relating.

The new By-Laws of the Association, which have been in formation for some time, were read and approved.

The House reaffirmed the principle of states' rights as related to membership in the Association, and despite a resolution from the New York delegation to change the By-Laws to allow anyone to become a member of the Association at the national level, the House voted unanimously that membership in the American Medical Association is to be decided by the local county medical society.

The House voted against federal aid to states except when those states were shown to be indigent.

It reaffirmed the attitude of the Association against those resolutions of the National Health Assembly which were ambiguous in character and openly espoused a national health insurance scheme. (Sec. 8, Resolutions of National Health Assembly.)

It was voted that the number of beds in the Veterans Administration hospitals should be limited to the present number, 147,000, and that veterans in the Administration be given the free choice of physicians and hospitals.

The resolution of the American Academy of Pediatrics to solicit federal aid for pediatric education was defeated.

It was moved and carried that interns be allocated to hospitals on the basis of yearly admissions. The Association was censured for its action in putting the health insurance of its employees into the hands of a commercial carrier, and it was voted that at the expiration of the present contract the insurance be given to both Blue Shield and Blue Cross.

The House voted unanimously in favor of the resolution creating two types of private duty nurses, one to be known as the "Registered Nurse" and the other as the "Certified Nurse."

After much discussion, the House voted that all American Red Cross blood banks should operate only in conjunction with the local medical societies and should be under the jurisdiction of such societies, and further that the term "free blood," as used in the publicity of the American Red Cross, be omitted in future publications.

Noteworthy at this Session was the unusual number of new officers elected during a single session. Dr. Ernest E. Irons of Chicago was elected President-Elect; Dr. Francis F. Borzell of Philadelphia, Vice Speaker, was elevated to the position of Speaker, replacing Dr. Roy W. Fouts, who became Vice President. Dr. Fouts had served five years as Speaker and five years as Vice Speaker. The new Vice Speaker chosen was Dr. James R. Reuling of Bayside, N. Y. Three new Trustees were elected: Dr. Walter B. Martin of Norfolk, Va., Dr. Edwin S. Hamilton of Kankakee, Ill., and Dr. Gunnar Gundersen of LaCrosse, Wis. Two new members of the Judicial Council were nominated by the President and elected by unanimous voice vote, and it is with pride that we acknowledge the signal honor conferred upon Florida by the election of Dr. Homer L. Pearson, Jr., to serve as one of these new members on the Council. The junior delegate was appointed to serve on the Reference Committee on Reports of Officers.

Your two delegates attended all of the sessions of the House and left the meeting more cognizant than ever before of the efficiency of its procedure, the profundity of its judgment and the wisdom of its decisions, all formulated through the unfettered democratic processes of free speech and secret ballot.

Respectfully submitted,
Louis M. Orr
Homer L. Pearson, Jr

SPECIAL GRADUATE COURSE SEPTEMBER 13-25

The Department of Medicine of The Graduate School of The University of Florida announces a Special Graduate Course to be given at The Medical Center (formerly Duval County Hospital) in Jacksonville September 13 through September 25 inclusive. This course is a part of the plan of The Department of Medicine to extend the graduate medical teaching in Florida.

The two weeks' course to be given in September will stress clinical demonstrations rather than didactic lectures.

The instruction in surgery, under Dr. Edward Jelks, will consist almost entirely of demonstrating and visualizing diagnosis and operative procedures and pathologic conditions encountered in the practice of surgery.

There will be medical rounds with presentation of clinical cases and diagnostic conferences headed by Dr. Webster Merritt.

On Tuesday, September 14, Thursday, September 16 and Tuesday, September 21 the gastrointestinal division, headed by Dr. James L. Borland, will hold ward rounds, clinical conferences and discussions on the role of intestinal parasites in pathology of the human.

The division of pediatrics, under Dr. Luther W. Holloway, will occupy Friday morning, September 17 and Friday morning, September 24, with ward rounds and clinical demonstrations each day.

The gynecology division, under Dr. Chas. J. Collins and Dr. Ferdinand Richards, will occupy parts of Monday morning, September 13, Thursday morning, September 16 and Wednesday morning, September 22.

Dr. Samuel R. Norris has charge of obstetrics and will stress the management of toxemia in pregnancy.

The division of urology, directed by Dr. Robert B. McIver, will occupy the morning of Saturday, September 18.

Lectures on orthopedics will be held under the direction of Dr. Charles B. Mabry.

In addition, there will be lectures on psychiatry by Dr. Sullivan G. Bedell, public health by Dr. Wilson T. Sowder, ear, nose and throat by Dr. H. Marshall Taylor, eye by Dr. Shaler Richardson, psychosomatic medicine by Dr. Frank G. Slaughter and diagnosis of brain tumors and management of common neurologic diseases by Dr. James G. Lyerly. Other members of the faculty will give lectures as a part of the program of the respective divisions already specified.

Programs have been mailed to all physicians in Florida. Registration will be limited to approximately fifty.

SOUTHERN MEDICAL ASSOCIATION MEETING

The forty-second annual meeting of the Southern Medical Association will be held at Miami from October 25 to 28 with the Dade County Medical Association as sponsor.

At a meeting of the executive committee on July 24, Dinner Key was selected as general headquarters for the following: registration; all section meetings, scientific, technical and hobby exhibits; and motion pictures. Dinner Key (the former Pan American Air Depot) is ten minutes' ride from the general hotel headquarters.

The evening programs, which will include the General Public Session, the General Session and the President's Ball, will be held at the Municipal Auditorium.

Hotel reservations will be handled by the Hotel Committee, Southern Medical Association Meeting, in care of City of Miami Convention Bureau, 320 N. E. Fifth Street, Miami 32.

AMERICAN COLLEGE OF PHYSICIANS ANNOUNCES 1949 ANNUAL SESSION

The American College of Physicians will conduct its Thirtieth Annual Session at New York, N. Y., March 28 through April 1, 1949. Dr. Franklin M. Hanger, Jr., of New York City is the chairman for local arrangements and the program of clinics and panel discussions. The president of the college, Dr. Walter W. Palmer, director of The Public Health Research Institute of the City of New York, Inc., and professor emeritus, Columbia University College of Physicians and Surgeons, is in charge of the program of morning lectures and afternoon general sessions.

Secretaries of medical societies are especially asked to note these dates and, in arranging meeting dates of their societies, to avoid conflicts with the college meeting, for obvious mutual benefits.

CONTAMINATED STOCKS OF SILIFORM AMPULS RECALLED

The Council on Pharmacy and Chemistry of the American Medical Association requests publication of the following press release, issued by the Food and Drug Administration on July 29, 1948:

"Druggists and the medical profession were urged today by the Federal Security Agency's Food and Drug Administration to return all stocks of Siliform Ampuls to the manufacturer. The Heilkraft Medical Company, Boston, Mass. This injection drug, which should be sterile, is potentially dangerous since samples collected on the market contain living organisms. Siliform is injected by some physicians and osteopaths in the belief that it will relieve patients suffering with rheumatism as claimed by the manufacturer. The Food and Drug Administration found the contaminated samples after a routine inspection at the Heilkraft factory disclosed that the Siliform Ampuls had been manufactured without sterilization. Intensive recall efforts by the manufacturer and the Food and Drug Administration for the past two weeks have not brought in all of the contaminated stocks. The article, which moves slowly, was shipped to 37 states from Maine to California and later was redistributed by wholesalers who cannot trace many of their sales. Some going back as far as 1946 have been found on the market. These ampuls may be in the hands of doctors, hospitals, clinics, and retail and wholesale druggists."

GRADUATE SHORT COURSE—1948

The Sixteenth Annual Graduate Short Course was held in Jacksonville June 28-July 3, inclusive. The lectures this year were outstanding in many ways. Dr. Thomas M. Durant's lecture on "Edema: Etiology and Management" and the lecture on "The Medical Care of the Atherosclerotic Ischemic Extremity" by Dr. Nathan DeVaughn were of special note. Also Dr. Keith S. Grimson's lectures on "The Treatment of Peptic Ulcer with Special Reference to Vagotomy" and on "Intestinal Obstruction" were outstanding. It is noteworthy that this year the lectures were of an advanced character and well worth while to physicians in special fields.

Two special courses were of unusual interest and should have attracted a larger number of doctors interested in the field of parasitology and gastroenterology.

Miami has asked that the Graduate Short Course be held there next year, and it is understood that a completely air-conditioned hotel will be available. It is probable that this request will receive favorable action though the Committee will not make its decision until early fall.

The list of physicians who registered for the Graduate Short Course and also the list of registrants for the special courses in parasitology and gastroenterology follow.

T. Z. Cason, M.D., Chairman
Medical Postgraduate Course Committee

PHYSICIANS BY CITIES

ARCADIA: Harold S. Agnew, George F. Highsmith, Charles H. Kirkpatrick, John A. Simmons. BROOKSVILLE: George R. Creekmore. CHIPLEY: Bayllye W. Dalton. COCOA: A. F. Thomas. CORAL GABLES: Mortimer D. Abrashkin, William P. Smith, William L. Wagener, Jr. CRESCENT CITY: James W. Davidson. CRYSTAL RIVER: William B. Moon. DAYTONA BEACH: Cleland D. Cochrane, Vaughan A. Shaw. DELAND: Hugh West. EUSTIS: Louis R. Bowen. FT. LAUDERDALE: Burt J. Canfield, Claus A. Peterson. FT. MYERS: Fred D. Bartleson. GAINESVILLE: L. W. Harrell, Charles J. Zinn. GRANDIN: James W. Brantley. GREEN COVE SPRINGS: Edwin H. Brown, Charles C. Gollinger. John M. Malone. HAVANA: James W. Sapp.

JACKSONVILLE: Archie J. Baker, Robert M. Baker, Donald M. Baldwin, John A. Beals, Sullivan G. Bedell, G. T. Black, John B. Black, F. Hardy Bowen, Alan Brown, Edward Canipelli, Cornelia M. Carithers, Hugh A. Carithers, Claude L. Carter, Turner Z. Cason, Joseph L. Chilli, Silas M. Copeland, Francis A. Copp, Samuel M. Day, Jr., Russell H. Dean, Lucien Y. Dyrenforth, Thomas S. Edwards, James V. Freeman, Lawrence E. Geeslin, Banks H. Goodale, Grace C. Hardy, William G. Harris, David F. Harwell, Luther W. Holloway, Gordon H. Ira, Edward Jelks, Nathaniel Jones, Alpheus T. Kennedy, F. Gordon King, Elmer E. Leitner.

Camillus S. L'Engle, Jr., Janet G. Leser, Louie Limbaugh, Frank G. Long (student), Joseph J. Lowenthal, James G. Lyerly, John M. McDonald, Charles B. Mabry, Lillian C. Mark, W. H. Mathews (Lt. J. G.), Webster Merritt, Kenneth A. Morris, Matthew E. Morrow, Samuel R. Norris, R. Judson Pearson, Jr., Harry A. Peyton, Harper L. Proctor, Ferdinand Richards, Willliam E. Ross, E. Thomas Sellers, Eugene D. Simmons, Lauren M. Sompayrac, Walker Stamps, Max Suter, Edwin C. Swift, H. Marshall Taylor, J. C. Taylor, Daniel B. Torn (dentist), Ernest W. Veal, Frederick J. Waas, Leo M. Wachtel, Ashbel C. Williams, Richard A. Worsham, Robert S. Wynn.

JUPITER: James C. Nowling. KEY WEST: James B. Parramore. LAKE CITY: Laurie J. Arnold, Jr., Robert B. Harkness. LEESBURG: George I. Engelhard, Howard G. Holland, George E. Stevens, H. Durham Young, Jr. LIVE OAK: Joshua M. Price. McINTOSH: James L. Strange. MARIANNA: Daniel A. McKinnon. MIAMI: John G. DuPuis, James O. Elam, Edward T. Gary, Jack Humphreys. MT. DORA: Sanford C. Colley, William L. Musser. NEW SMYRNA BEACH: William C. Chowning. OCALA: Eugene G. Peek.

ORLANDO: L. Paul Foster, Duncan T. McEwan. OVIEDO: J. William Martin.

PALATKA: James W. Ferris. PENSACOLA: Gustav N. Click, George W. Morse, Walter C. Payne, Thurlow W. Reed. ST. AUGUSTINE: Joseph A. Shelley, A. Clark Walkup. ST. PETERSBURG: Roscoe H. Knowlton. TALLAHASSEE: Laurie L. Dozier, James H. Pound, Bricey M. Rhodes. TAMPA: Elsie M. Gilbert. UMATILLA: Robert W. Ferguson. VERO BEACH: John P. Gifford, Erasmus B. Hardee, James C. Robertson. WINTER PARK: George R. Crisler.

ALABAMA—BIRMINGHAM: W. Nicholson Jones (faculty). GEORGIA—AUGUSTA: Nathan M. DeVaughn (faculty). FOLKSTON: W. R. McCoy (faculty). LOUISIANA—NEW ORLEANS: Neal Owens (faculty). NORTH CAROLINA—DURHAM: Keith S. Grimson (faculty), W. L. Thomas (faculty). PENNSYLVANIA—PHILADELPHIA: Thomas M. Durant (faculty). TENNESSEE—MEMPHIS: James G. Hughes (faculty).

REGISTRANTS FOR COURSES IN PARASITOLOGY AND GASTROENTEROLOGY

DAYTONA BEACH: Morris B. Seltzer, Vaughan A. Shaw. FT. LAUDERDALE: Burt J. Canfield. GRANDIN: James W. Brantley. JACKSONVILLE: Charles E. Aucremann, James L. Borland, Phillip W. Horn, Gordon H. Ira, F. Gordon King, Janet G. Leser, Joseph J. Lowenthal, A. Sherrod Morrow, Nelson A. Murray, Robert H. Nickau, Edwin C. Swift, Sidney Stillman. LAKE WORTH: Sidney Davidson. Orlando: L. Paul Foster, Albert C. Kirk, Joseph G. Seltzer. PENSACOLA: Gustav N. Click. ST. PETERSBURG: Roscoe H. Knowlton, Frank W. Price. WEST PALM BEACH: David A. Newman. WINTER PARK: Lucien E. Myers.

GEORGIA—WOODBINE: Sam C. Atkinson.

BLUE SHIELD PROGRESS
THE DOCTOR'S ROLE

At the time of the writing of this article there are over 1,350 physicians in the state of Florida participating in the Blue Shield Plan. There are presently 55,400 people in this state enroled in the Blue Shield Plan. This number, however, represents only 2.3 per cent of the state's population, and while every effort is being made to educate the public to the advantages of the doctors' own plan, the road ahead is long and steeped with obstacles.

In order to combat socialized medicine, and the time is growing short, it is imperative that free patients be given the opportunity of choosing a free doctor from among free doctors. Physicians participating in the Blue Shield Plan are urged to take advantage of every opportunity to secure additional participation by the public in this plan.

Every patient should be asked at the time arrangements are made for surgery, or treatment covered by the Blue Shield Plan, whether or not he is a Blue Shield member. If the patient is not a member, the physician is urged to make every effort to sell him on the idea of Blue Shield. It should be understood, of course, by both the physician and the patient that Blue Shield does not cover anticipated surgery. The physician might, however, take advantage of the fact that the patient is not covered for the operation at hand to stress the importance of Blue Shield coverage for any such future emergencies for the patient or his family.

Enrolment in Blue Shield is available to persons employed in firms having five or more workers. The employee, spouse and children under nineteen years of age may be carried under a family contract, all of whom receive the same benefits. The income limitations are $2,000 per year for single persons and $3,000 per year for families. Subscribers whose incomes fall into these categories receive the services of participating physicians for the amounts set up in the Fee Schedule. The physician makes his regular charges to patients whose incomes exceed these amounts, and is allowed the amount set forth in the Fee Schedule as a credit on the total charge. A minimal and fair payment for good medical care when the patient's income or resources are limited is one of the principles upon which Blue Shield was founded. Physicians desiring descriptive folders on the Blue Shield Plan to keep on hand in their offices may write to the home office of the Florida Medical Service Corporation, P. O. Box 1798, Jacksonville.

For enrolment purposes, the state of Florida is divided into eight areas, each served by a representative of the Blue Shield Plan. These employees are ready and willing at all times to cooperate and work with physicians in any matters pertaining to Blue Shield.

The Blue Shield Plan has made remarkable progress in the two years since its organization, but its growth could be greatly helped by the whole hearted support and cooperation of every physician in the state. In addition to the points mentioned, participating physicians are asked to help further in the Blue Shield movement by stressing to all physicians who are not now participating in the plan the importance of doing so.

We must realize the Blue Shield is OUR plan, and that all of us should do everything possible to further its growth throughout the state.

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PUBLIC RELATIONS FOR
FLORIDA MEDICAL ASSOCIATION

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Editor's Note:

The purpose of the Academy is to promote a program of public relations under the supervision of the Florida Medical Association. At present all officers and members of the Academy are also members of the Florida Medical Association.

WEEKLY HEALTH COLUMN

To do a satisfactory job in any kind of venture it is first necessary to have good tools with which to work. Public relations has several. Well at the top of the list is the newspaper, from the large metropolitan daily to the small country weekly. Medical public relations needs them all.

Florida has many small communities and rural areas of which the smaller newspaper is a basic and integral part. Their editors are generous, as a rule, in giving coverage to information dealing with health and well-being. They require, however, a slightly different style of presentation than the dailies.

In view of this need a special column, known as "Health Topics," is now being released exclusively to weekly and semiweekly newspapers. The first one, dealing with sunburn, was issued to all such newspapers in the state on July 19. Each week a new topic will be discussed and submitted to such of the weeklies as have expressed a desire for this service. Every weekly newspaper editor has been contacted, and at this writing forty-nine have returned a favorable reply.

The subject is treated in nontechnical language as nearly as possible. Each topic is carefully edited by an official of the Academy of Public Medicine before being released. A continuous theme will be pursued, directly or indirectly, of "see your family doctor."

A special format has been designed for heading the column. This explains the source of the information and includes credit to the Florida Medical Association and the local county medical society. The editor makes the final decision as to how the column will appear in his paper. Some may not use the submitted type, but newspaper men are usually scrupulous about giving credit where due.

The column heading, just as it reaches the editor, is reproduced here. Watch for it in your local weekly newspaper.

THE BREEZE, Jacksonville, not only carried the first issue of "Health Topics," but also ran a special announcement that it would be a regular feature each week. In a letter to the Academy Mr. Warner S. Hull, editor and publisher of this weekly, says, "In our opinion a column of health suggestions will fill a long-felt need. Trouble in the past has been too many unqualified persons attempting such advice. . . . Thanks again for doing what should have been done long ago."

Paul W. Ramsey, publisher of the CITRUS COUNTY CHRONICLE and THE DUNNELLON SUN, wants a mat of the heading for "Health Topics," just as it appears below. He prefers to set his own type but feels that adding the heading would give the column distinction. Mr. Ramsey tells us, "I want to run your health column as a regular feature."



STATE NEWS ITEMS

Any member desiring to read a paper at one of the Scientific Assemblies at the 1949 annual meeting in Belleair is requested to communicate with Dr. Chas. J. Collins, 1503 Kuhl Avenue, Orlando, chairman of the Association's Committee on Scientific Work.

Dr. Collins urges that any member making application should submit a copy of his paper or a fifty word synopsis.

All applications must be received by Dr. Collins before the end of December, preferably in October or November, to permit time for arranging a well balanced program.

Mr. Nelson P. Moyer, who joined the staff of the headquarters office of the Association in February of this year, has been promoted to the position of assistant to Dr. Stewart G. Thompson, managing director.

The first national public relations conference will be held in St. Louis on Nov. 27, 1948. This conference immediately precedes the annual secretaries-editors meeting on November 28 and 29, which is held in conjunction with the annual Interim Session of the American Medical Association, November 28 to December 3.

Dr. Alfred E. O'Neil, formerly of Miami, announces the removal of his office for general medical practice to 163 Hialeah Drive, Hialeah.

Dr. J. Lancelot Lester, Jr., has opened offices in Key West, his native town, after completing his residency in surgery at Jackson Memorial Hospital in Miami.

Dr. Allen S. Shepard of Key West left the latter part of August for four weeks' postgraduate study at the Flowers and Fifth Avenue Hospitals in New York City.

Dr. Herman K. Moore of Key West is completing four weeks' postgraduate study at the Harvard University medical school in Boston.

At a meeting of the Board of Governors held on July 25, 1948 in Jacksonville, seven physicians were elected honorary members of the Association on the recommendations of various county medical societies. They are Drs. B. L. Arms, Haines City; Leonard A. Baker, Miami; Annette M. Feaster and Orion O. Feaster, St. Petersburg; John E. Hall, Miami; Sarah P. White, Tallahassee; and G. H. Withers, Albuquerque, N. M.

The board also designated a special price of $3.00 as annual subscription to The Journal for those honorary members who wish to receive it.

The annual meeting of the Florida Public Health Association will be held in Panama City on October 7, 8 and 9. Members of the Florida Medical Association are cordially invited to attend.

Dr. Warren W. Quillian of Coral Gables addressed the South Carolina Medical Association as the official guest from Florida on May 13 at its Centennial celebration in historic Charleston. In the treatment of his subject, "Looking Back in Pediatrics," Dr. Quillian discussed the development of many influences which have been brought to bear on the practice on medicine from without the profession during the past several decades.

WANTED: Registered laboratory and x-ray technician. Good salary with full maintenance. Florida State Hospital No. 2, Arcadia, Fla.

MEDICAL DISTRICT MEETINGS

The chairman of the Council, Dr. Herman Watson, has just announced that the dates of the four Medical District meetings have been officially set by the Council as follows:

Live Oak, Monday, Oct. 18, 1948

Daytona Beach, Tuesday, Oct. 19, 1948

Bradenton - Sarasota, Wednesday, Oct. 20, 1948

West Palm Beach, Friday, Oct. 22, 1948

BIRTHS AND DEATHS

BIRTHS

Dr. and Mrs. John R. Browning, Jacksonville, announce the birth of a daughter on July 12, 1948.

DEATHS— MEMBERS

Dr. F. Leslie Snyder, Jr., Ft. Lauderdale July 28, 1948

DEATHS—OTHER DOCTORS

Dr. John W. Murray, Jr., Raiford July 26, 1948

COMPONENT SOCIETY NOTES

BAY

Dr. Thos. M. Boulware of the Medical College of Birmingham, University of Alabama, spoke to members of the Bay County Medical Society at the July 13 meeting. He spoke on "Obstetrics in General Practice."

MARION

At the June meeting of the Marion County Medical Society, plans were made to hold the ensuing three monthly meetings with staff members of the local hospital. Dr. Richard C. Cumming, chairman of the society public relations committee, presented a report and discussed the radio programs which are continuing to be arranged with the local radio station.

A committee, consisting of Drs. Harry F. Watt, Richard C. Cumming and Eugene G. Peek, was appointed to compose a eulogistic resolution for the late Dr. Henry C. Dozier, a member of the society. Mrs. Painter spoke to the members on the nutritional program to be held in the schools during the coming year.

Attending the meeting were Drs. William H. Anderson, Jr., Hugh H. Barfield, Richard C. Cumming, T. Hartley Davis, Henry L. Harrell, Carl S. Lytle, John N. Moore, Eugene G. Peek and Harry F. Watt.

RESOLUTION OF LOCAL SOCIETY ON THE LATE DR. HENRY C. DOZIER

Whereas the passing of Dr. Henry C. Dozier, on June 15, 1948, was accompanied by a distinct sense of loss on the part of those of us who knew him well and were associated with him for many years, and

Whereas the community of Ocala and Marion County and the state of Florida knew Dr. Dozier as an outstanding physician and surgeon, being served well and faithfully by him for more than a quarter of a century, and

Whereas his friends and fellows in the profession will miss the leadership, wisdom and association of this well trained and experienced doctor of medicine,

Therefore, be it resolved that the Marion County Medical Society hereby record its respects and regrets in the passing of Dr. Dozier and express the hope that the life he lived may be an inspiration to his fellow members of the profession and a heritage of priceless value to his family.

Be it further resolved that a copy of these resolutions be sent to the family of Dr. Dozier, to the newspaper and spread on the records of the Society.

Committee: E. G. Peek
H. F. Watt
R. C. Cumming

MONROE

Members of the Monroe County Medical Society met recently with a local committee representing the Parent-Teacher Association to discuss the advisability of having a complete preschool series of inoculations for every child in the county. They also discussed measures for segregating students with certain contagious diseases.

SARASOTA

The entire membership of the Sarasota County Medical Society has paid its 1948 Association dues.

HENRY CUTTINO DOZIER

Dr. Henry C. Dozier, retired Ocala physician, died during his sleep on June 16, 1948 at his summer home in Lavallette, N. J. He was 68 years of age.

Dr. Dozier was born on Oct. 23, 1879 in Fernandina and moved to Ocala in childhood with his parents. After attending local schools, he entered the University of Pennsylvania School of Medicine in Philadelphia, from which he was graduated in 1903. Following the completion of his internship in 1904, Dr. Dozier practiced medicine in Columbia, S. C., and taught at the University of the South, Sewanee, Tenn., returning to Ocala in 1907 to practice medicine. A cardiac condition forced him to retire in 1941.

In 1904 he was married to Miss Corrie Williams of Minetta, S. C.

Dr. Dozier was a member of the Marion County Medical Society and the Florida Medical Association. In 1929 he served as president of the latter organization, having been its first vice president in 1917. Throughout the years of his activity in organized medicine, he was a leader in the Association. During the early 1930's he was instrumental in helping to establish a cooperative relationship with the press and radio over the state of Florida, serving as the first chairman of the Committee on Public Relations. He also had served as chairman and member of the Committees on Legislation and Public Policy, Medical Economics, and Necrology. At the time of his death he was a life member of the Association. He also was a member of the American Medical Association and the Southeastern Surgical Con-

(Continued on page 176)

"...such as Metamucil..."*

For the treatment of the spastic colon the author suggests diet, elimination of the nervous element and "bulk producers." As examples of these he lists "agar-agar, in finely powdered form, in flakes, or in cereal-like form; derivatives of psyllium seed, such as Metamucil . . . ."*

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*Glafke, W. H.: Spastic Colon, M. Clin. North America 26:805 (May) 1942.

†Council on Pharmacy and Chemistry: New and Nonofficial Remedies, 1947, Philadelphia, J. P. Lippincott Company, 1947, p. 320.



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gress, and was a fellow of the American College of Surgeons.

Until ill health necessitated his inactivity, Dr. Dozier was active in civic enterprises. He served as chairman of the local selective service board in the early part of World War II. One of his last public services was membership on a veterans' lot committee which distributed lots offered by Ocala to war veterans. He also was a member of the Kiwanis Club. Dr. Dozier was a member of the Blessed Trinity Catholic Church.

Survivors include his widow, Mrs. Corrie Dozier, who was with him in New Jersey; a son, Henry C. Dozier, Jr., Ocala attorney; a daughter, Mrs. Hugh Chace of Ridgewood, N. J.; and a sister, Mrs. Josie Coquillard of Orlando.

FREDERICK WILLIAM KRUEGER

Dr. Frederick W. Krueger of Jacksonville died suddenly at his home on July 6, 1948. He was 51 years of age.

Dr. Krueger was born in Westphalia, Germany, on Oct. 17, 1896, the son of Fred and Louise Peithmann Krueger. When he was six years of age, the family came to the United States and settled on a Nebraska farm. Following completion of his elementary and secondary education in local schools, Dr. Krueger entered the University of Nebraska in Omaha, from which he received his Bachelor of Science degree in 1924 and his Doctor of Medicine degree in 1926.

He then came to Jacksonville to serve an internship at St. Luke's Hospital. After practicing medicine in Kansas for a short time, he returned to Jacksonville where he had been a physician and surgeon for the past twenty-two years.

Dr. Krueger was a member of the Duval County Medical Society and of the Florida Medical Association, and was a fellow of the American Medical Association. He also was a member of the Southern Medical Association, the Midwest Medical Association, the American Association of Industrial and Railway Surgeons and the Florida Association of Industrial and Railway Surgeons. He was on the staff of St. Luke's Hospital and was a member of the visiting staffs of St. Vincent's, Brewster and the Duval County Hospitals.

Dr. Krueger was a charter member of St. Mark's Lutheran Church and at the time of his death was chairman of the church finance committee and a member of the building committee, the Church Council and Brotherhood.

He had participated in the drive for the Baptist Hospital Fund, was a member of the board of trustees of Newberry College, Newberry, S. C., and was a trustee of the Florida Naval Academy at St. Augustine.

During World War I Dr. Krueger served in the United States Navy. He was a member of the American Legion Post No. 88821. Socially, Dr. Krueger was a member of the Ponte Vedra and San Jose Country Clubs.

Survivors include his widow, Mrs. Lydia Krueger; a daughter, Miss Annabelle Louise Krueger; two sons, Frederick Charles and John J. Krueger, all of Jacksonville; four brothers, the Rev. C. F. H. Krueger, pastor of St. John's Lutheran Church of Jacksonville, Fred Krueger of Gilead, Neb., Christ Krueger of Hillrose, Colo., and Henry Krueger of Denver, Colo.; and three sisters, Mrs. Adolph Fangmeir, Mrs. George Fangmeir and Mrs. Frank Hellbrush, all of Gilead, Neb.

SAMUEL PULESTON

Dr. Samuel Puleston of Sanford died on May 29, 1948 in a Jacksonville hospital. He was 67 years of age.

Dr. Puleston was born in 1880 in Weatherford, Texas, and moved to Florida with his family during his early childhood. He resided in Monticello until he entered the University of Maryland School of Medicine and College of Physicians and Surgeons in Baltimore. Following his graduation in 1902 he served an internship in a Baltimore hospital for a year and then served a residency in the Atlantic Coast Line Hospital in Waycross, Ga. Dr. Puleston, a surgeon, then moved to Sanford, where he practiced continuously until the time of his death.

A charter member of the Seminole County Medical Society, Dr. Puleston served as its first president. He also was a life member of the Florida Medical Association and a member of the American Medical Association. He had been Chief of Staff of the Fernald Laughton Hospital in Sanford since its establishment. Locally, he was a charter member of the Sanford Rotary Club and a member of the Masonic Lodge.

Surviving are his widow, Mrs. Lou Puleston; two daughters, Mrs. R. F. Spencer of Claversack, N. Y., and Mrs. K. A. Shangraw of Belmont, Mass.; his mother, Mrs. Tom Puleston, and a sister, Mrs. Junius Turnbull, both of Sanford.



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1. Kasper, J. A. and Jeffrey, I. A.: A Simplified Benedict Test for Glycosuria, Amer. J. Clin. Pathology, *14*:117-21 (Nov.) 1944.

2. Haid, W. H.: The Use of Screening Tests in the Clinical Laboratory, J. Amer. Med. Tech., *8*:606-14 (Sept.) 1947.

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DADE COUNTY AUXILIARY INSTALLS NEW OFFICERS

The Woman's Auxiliary to the Dade County Medical Association installed new officers for the 1948-1949 season on May 10 at a chowder party held in the Biscayne Bay Yacht Club in Miami.

After a delicious chowder luncheon, the retiring president, Mrs. Perry D. Melvin, turned the meeting over to Mrs. Robert O. Lyell who served as installation officer. Mrs. Lyell introduced the new officers individually and charged each one with the requirements and duties of her office.

The new slate includes Mrs. Richard F. Stover, president; Mrs. L. Washington Dowlen, president-elect; Mrs. Milton M. Coplan, vice president; Mrs. E. Weir Cullipher, recording secretary; Mrs. Frederick LeDrew, corresponding secretary; and Mrs. L. Washington Dowlen, treasurer.

Following the installation ceremonies, Mrs. Stover announced the appointment of other members of her executive board, including Mrs. Oden A. Schaeffer, historian; Mrs. C. Russell Morgan, Jr., parliamentarian; Mrs. James H. Putman, hospitality chairman; Mrs. Roger J. Forastiere, membership chairman; Mrs. Raymond L. Evans, publicity chairman; Mrs. Donald F. Marion, social chairman; Mrs. W. Carlton Rentz, Jr., program chairman; Mrs. Robert F. Mikell, projects chairman; and Mrs. Nelson M. Black, Jr., probation members chairman.

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From where I sit
by Joe Marsh

Who Is This Man?

Now and then, in the pages of the *Clarion*, I run a biographical quiz, under the heading of "Who Is This Man?" For instance . . .

"He was one of the earliest lovers in American history . . .

"And yet he was too shy to court a woman outright . . .

"He came to the New World on the Mayflower . . .

"A cooper to repair the beer barrels accompanying the Pilgrims . . .

"Who is this man?"

I thought that everybody was stumped. But not Ma Hopkins, who returned the clipping to me with "John Alden" on it. She recognized all the clues—including that reference to "beer" and "cooper."

For Ma—who's read her history, knows that beer as the beverage of moderation, is as old in this land of ours as the never-ending American search for tolerance which brought the Pilgrims over to this country in the first place.

Joe Marsh

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PALM BEACH COUNTY AUXILIARY ELECTS OFFICERS

Mrs. Kenneth E. Montgomery has been re-elected president of the Woman's Auxiliary to the Palm Beach County Medical Society. Other new officers are Mrs. A. Scott Turk, first vice president; Mrs. Oscar L. Kelley, second vice president; Mrs. Russell D. D. Hoover, secretary; and Mrs. Charles McD. Harris, Jr., treasurer.

Mrs. Montgomery has appointed the following members as committee chairmen: Mrs. R. Gaylord Lewis, parliamentarian; Mrs. James L. Carlisle, publicity; Mrs. Cecil M. Peek, Hygeia; Mrs. Younger A. Staton, bulletin; Mrs. Edgar W. Stephens, Jr., doctor's day; Mrs. Ralph M. Overstreet, Jr., hospitality; Mrs. A. Scott Turk, program; Mrs. Oscar L. Kelley, organization; Mrs. Richard S. Gill, public relations; Mrs. Alvin E. Murphy, Pine Ridge project.

One project, the Medicine Cabinet, has produced the following results since January 1: 90 prescriptions for indigents, amounting to $290; 1 truss, $20.00; 1 electric stocking, $5.00; a sacro-belt, $33.50. The Community Chest of Palm Beach has contributed $750 and the Community Chest of West Palm Beach has contributed $375 to the Cabinet for 1948, according to Mrs. Mark M. Byrd, secretary.

The Auxiliary has voted to continue its Pine Ridge nursery project for another year. During the past year the members made 30 gowns, 11 reclining blankets, 11 bassinet pads, 30 bassinet sheets and 12 crib sheets.

DOCTOR'S DAY SPONSORED BY POLK COUNTY AUXILIARY

The ladies of the Woman's Auxiliary to the Polk County Medical Society entertained Polk County physicians and their families with a covered dish supper party in honor of Doctor's Day, April 30, 1948, at the Civic Center in Winter Haven.

The Civic Center and buffet tables were beautifully decorated with spring flowers. During the supper hour, a radio tribute to doctors everywhere and to Polk County physicians in particular was given by Mrs. Robert J. Jahn, president of the Polk County Auxiliary, over Winter Haven Radio Station WSIR. The tribute concluded with Osler's poem, "The Doctor."

Later, a social hour was enjoyed by all present with bingo games under the direction of Mrs. William P. Logan of Lakeland. Amusing, inexpensive prizes were awarded.

Mrs. Robert J. Jahn, President

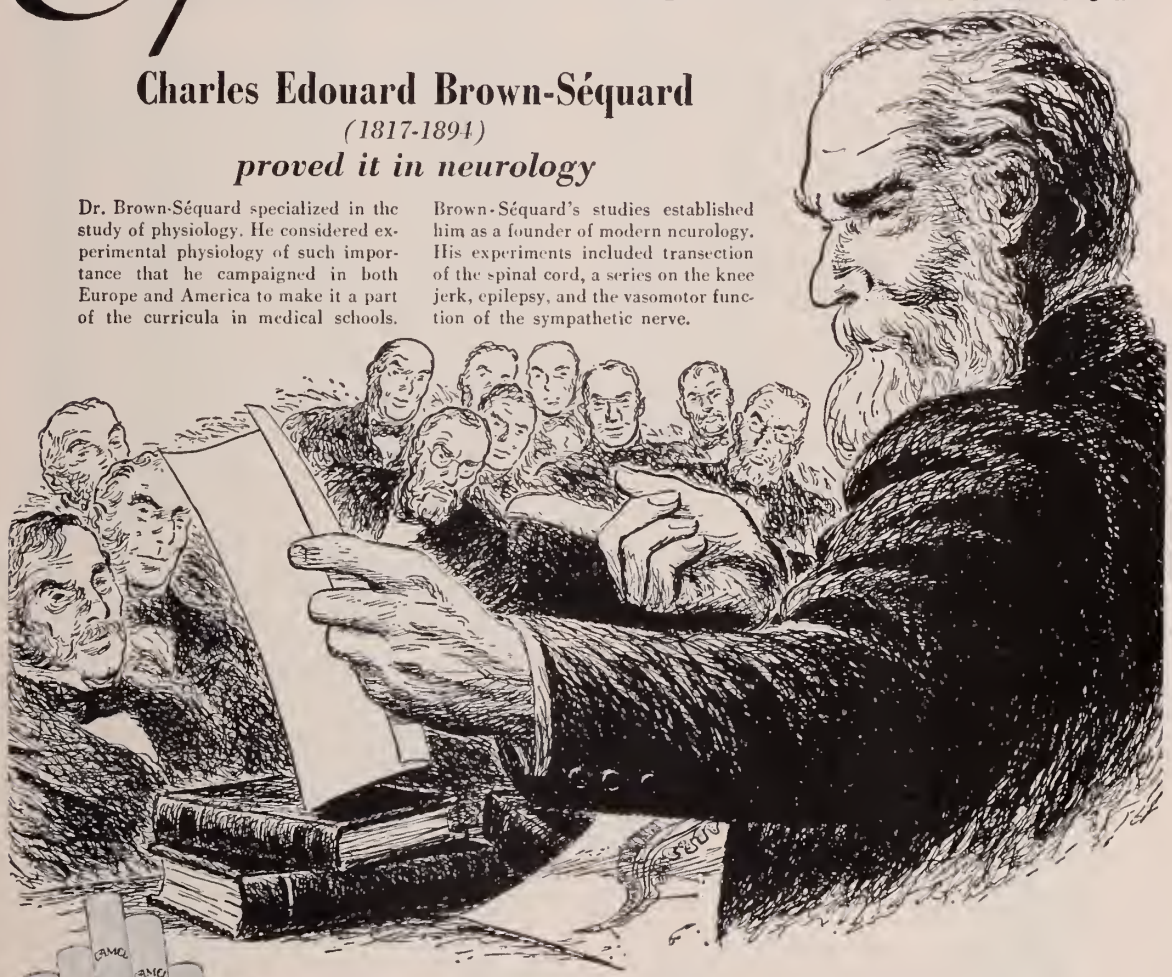
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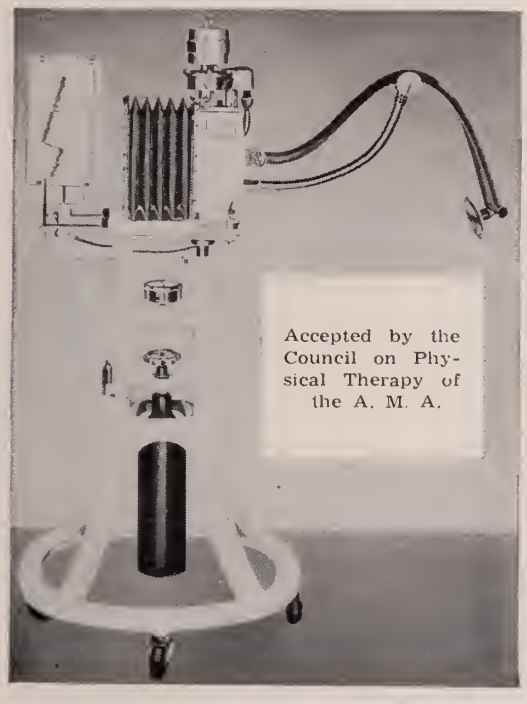
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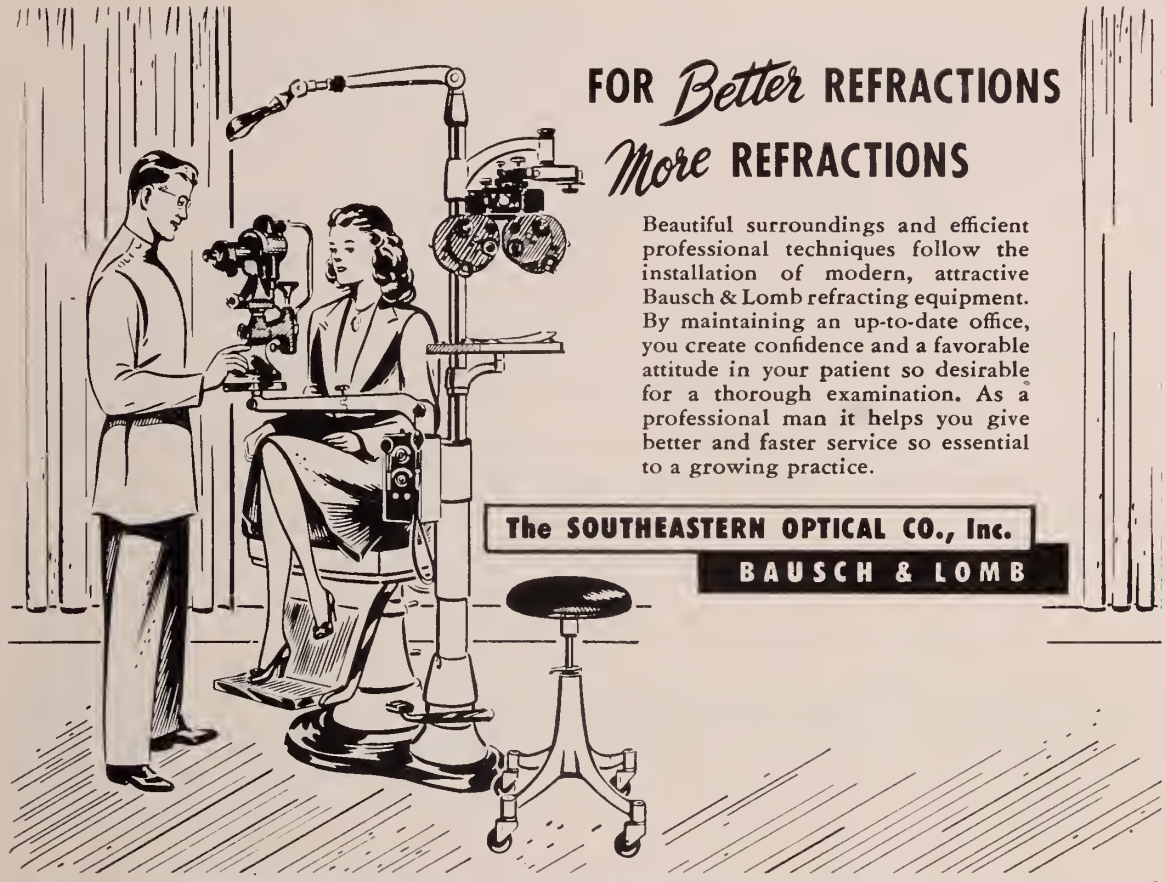
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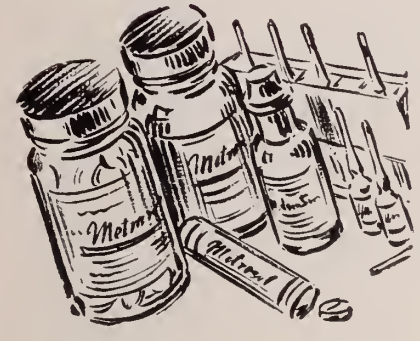
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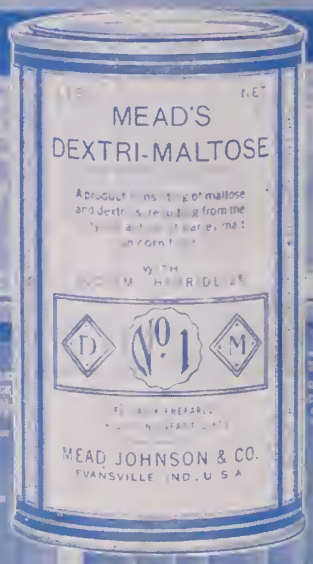
SCHEDULE OF MEETINGS

ORGANIZATION	PRESIDENT	SECRETARY	ANNUAL MEETING
ida Medical Association	Joseph S. Stewart, Miami	Robert B. McIver, Jacksonville	Belleair, Apr. 10-13, 1949
ida Medical Districts	Herman Watson, Lakeland	Council Chairman	
-Northwest	Irby H. Black, Live Oak	William P. Hixon, Pensacola	Live Oak, Oct. 18, 1948
-Northeast	Rabun H. Williams, Eustis	Charles C. Grace, St. Augustine	Daytona Beach, Oct. 19, 1948
-Southwest	John M. Butcher, Sarasota	H. Quillian Jones, Ft. Myers	Bradenton-Sarasota, Oct. 20, '48
-Southeast	Russell B. Carson, Ft. Lauderdale	Erasmus B. Hardee, Vero Beach	West Palm Beach, Oct. 22, 1948
ida Specialty Societies			
erm. and Syph., Soc. of	A. Buist Litterer, Miami	Wesley W. Wilson, Tampa	Belleair, April 10, 1949
enl. Practice of Med.	M. Crego Smith, Clearwater	Walter E. Murphree, Gainesville	Belleair, April 10, 1949
ealth Officers' Society	Roger F. Sondag, Jacksonville	Lorenzo L. Parks, Jacksonville	Belleair, April 10, 1949
ıdustrial & Railway Surgeons	F. Hardy Bowen, Jacksonville	J. H. Mitchell, Jacksonville	Belleair, April 10, 1949
eurology & Psychiatry	James G. Lyerly, Jacksonville	William H. McCullagh, Jacksonville	Belleair, April 10, 1949
b. and Gynec. Society	Chas. J. Collins, Orlando	Dorothy D. Brame, Orlando	Belleair, April 10, 1949
phthal. & Otol., Soc. of	Bascom H. Palmer, Miami	W. Jerome Knauer, Jacksonville	Belleair, April 10, 1949
rthopedic Society	Charles B. Mabry, Jacksonville	Eugene L. Jewett, Orlando	Belleair, April 10, 1949
athological Society	James N. Patterson, Tampa	Gretchen V. Squires, Pensacola	Belleair, April 10, 1949
ediatric Association, State	Edgar W. Stephens, W. P. Beach	Hugh A. Carithers, Jacksonville	Belleair, April 10, 1949
roctologic Society	Dean W. Hart, St. Petersburg	Frederick E. Farrer, Miami	Belleair, April 10, 1949
adiological Society	James F. Pitman, Lake City	Floyd K. Hurt, Jacksonville	Belleair, April 9-10, 1949
rological Society	Milton M. Coplan, Miami	Russell B. Carson, Ft. Lauderdale	Belleair, April 10, 1949
ida—			
:ademy, Public Medicine	Robert T. Spicer, Miami	Shaler Richardson, Jacksonville	Belleair, April 13, 1949
asic Science Exam. Board	Paul A. Vestal, Winter Park	M. W. Emmel, D.V.M., Gainesville	Gainesville, Nov. 6, 1948
ental Society, State	Horace L. Cartee, D.D.S., Miami	John I. Todd, D.D.S., Jacksonville	Hollywood, Dec. 12-15, 1948
ospital Association	Mr. James T. Pate, Jacksonville	Mr. H. A. Schroder, Jacksonville	
ospital Service Corporation	Mr. W. E. Arnold, Jacksonville	Mr. H. A. Schroder, Jacksonville	
[edical Examining Board	Homer L. Pearson, Jr., Miami	Frank D. Gray, Orlando	Jacksonville, Nov. 29-30, '48
[edical Postgraduate Course	Turner Z. Cason, Jacksonville	Chairman	
[edical Service Corporation	Leigh F. Robinson, Ft. Lauderdale	Herbert E. White, St. Augustine	
urses Association, State	Miss Elizabeth Reed, Jacksonville	Miss Helen Shearston, Miami	West Palm Beach, Oct. 17-20, '48
harmaceutical Association, State	Mr. D. M. Weaver, Miami	Mr. R. Q. Richards, Ft. Myers	
ublic Health Association	Wilson T. Sowder, Jacksonville	Mr. Fred B. Ragland, Jacksonville	Panama City, Oct. 7-9, 1948
uberculosis & Health Assn.	Judge Ernest E. Mason, Pensacola	Mr. Walton MacJordan, Orlando	May, 1949
Voman's Auxiliary	Mrs. L. E. Parmley, Winter Haven	Mrs. C. R. Morgan, Jr., Miami	Belleair, Apr. 10-13, 1949
erican Medical Association	R. L. Sensenich, South Bend, Ind.	Geo. F. Lull, Chicago	Atlantic City, June 6-10, 1949
1. A. Interim Session			St. Louis, Nov. 30-Dec. 3, '48
thern Medical Association	E. L. Henderson, Louisville, Ky.	Emmett B. Carmichael, Atlanta	Miami, Oct. 25-28, 1948
ama Medical Association	J. Paul Jones, Camden, Ala.	Douglas L. Cannon, Montgomery	Montgomery, Ala., Apr. 19-21, 1949
rgia, Medical Assn. of	Edgar Hill Greene, Atlanta	Edgar D. Shanks, Atlanta	Savannah, Ga., May 10-13, '49
. Hospital Conference	Mr. Burton M. Battle, New Orleans	Mr. R. F. Whitaker, Atlanta	Biloxi, Miss., April 27-29, '49
theastern Allergy Assn.	J. Warrick Thomas, Richmond, Va.	Kath. B. MacInnis, Columbia, S. C.	
theastern, Am. College Phys.	Webster Merritt, Jacksonville	Florida Program Chairman	Atlanta, 1948
theastern, Am. Urological Assn.	Harold P. McDonald, Atlanta	Russell B. Carson, Ft. Lauderdale	Boca Raton, March 21-24, '49
theastern Surgical Congress	Gilbert Douglas, Birmingham, Ala.	B. T. Beasley, Atlanta	Biloxi, Miss., Jan. 24-27, '49

Every available means for checking has been used. Notification of errors or omissions should be mailed to P. O. Box 1018 (Fla. Theatre Bldg.), Jacksonville 1, for use in compiling the next Journal.

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Vol. XXXV OCTOBER, 1948 No. 4

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Rickets may exist in a subclinical form in as many as 46.5 percent of children between the ages of two and fourteen.[1]





The prevalence of "hidden rickets" in older children, confirmed by roentgenologic studies, demands that the old practice of discontinuing vitamin D administration after two or three years of age be reevaluated. Even though the effect of subclinical rickets on the health and development of the older *well child* may not be apparent, it is not unlikely that the *sick child* will be hampered by a deficit of vitamin D. "Our studies as a whole afford reason to prolong administration of vitamin D . . . and especially indicate the necessity to suspect and to take the necessary measures to guard against rickets in sick children."[1]

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(1) Follis, R. H.; Jackson, D.; Eliot, M. M., and Park, E. A.: Am. J. Dis. Child. 61:1 (July) 1941.

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formative

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From birth to at least the age of 14 years, investigators now agree children are susceptible to rickets, with scarcely diminished frequency.[1]

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1. Follis, R. H., Jackson, D., Eliot, M. M., and Park, E. A.: *Am. Jour. Dis. Child.*, 66:1, July, 1943.
2. Stearns, G.: *Jour. Lancet*, 63:344, Nov., 1943.

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Volume XXXV OCTOBER, 1948 No. 4

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This Journal is not responsible for the opinions and statements of its contributors.

Published monthly at Jacksonville, Florida. Price $5.00 a year; single numbers, 50 cents. Address Journal of the Florida Medical Association, P. O. Box 1018 (Fla. Theater Bldg.), Jacksonville 1, Fla. Telephone 5-0577. Accepted for mailing at special rate of postage provided for in Section 1103, Act of Congress of October 3, 1917; authorized October 16, 1918. Entered as second-class matter under Act of Congress of March 3, 1879, at the post office at Jacksonville, Florida. October 23, 1924.

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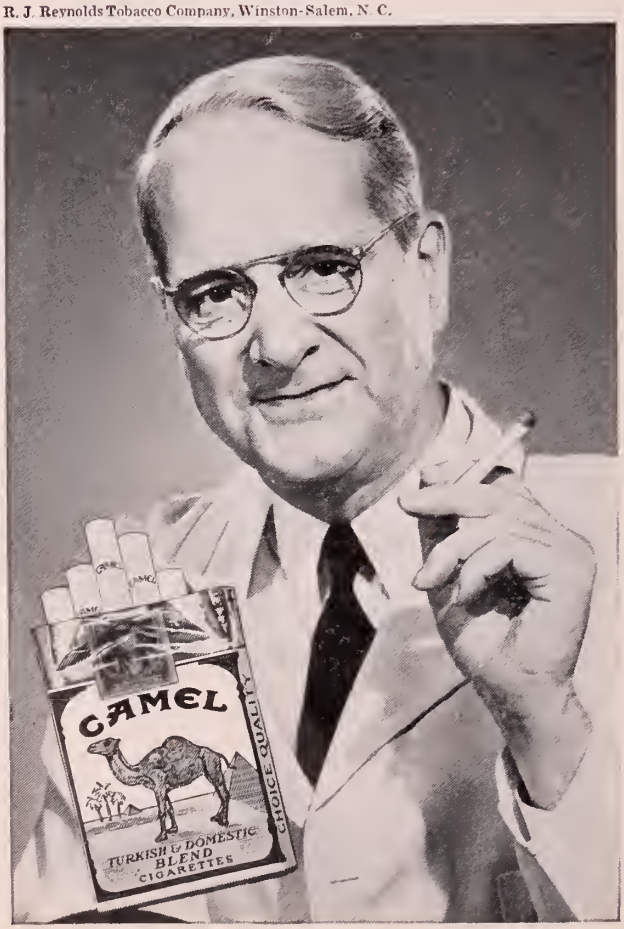


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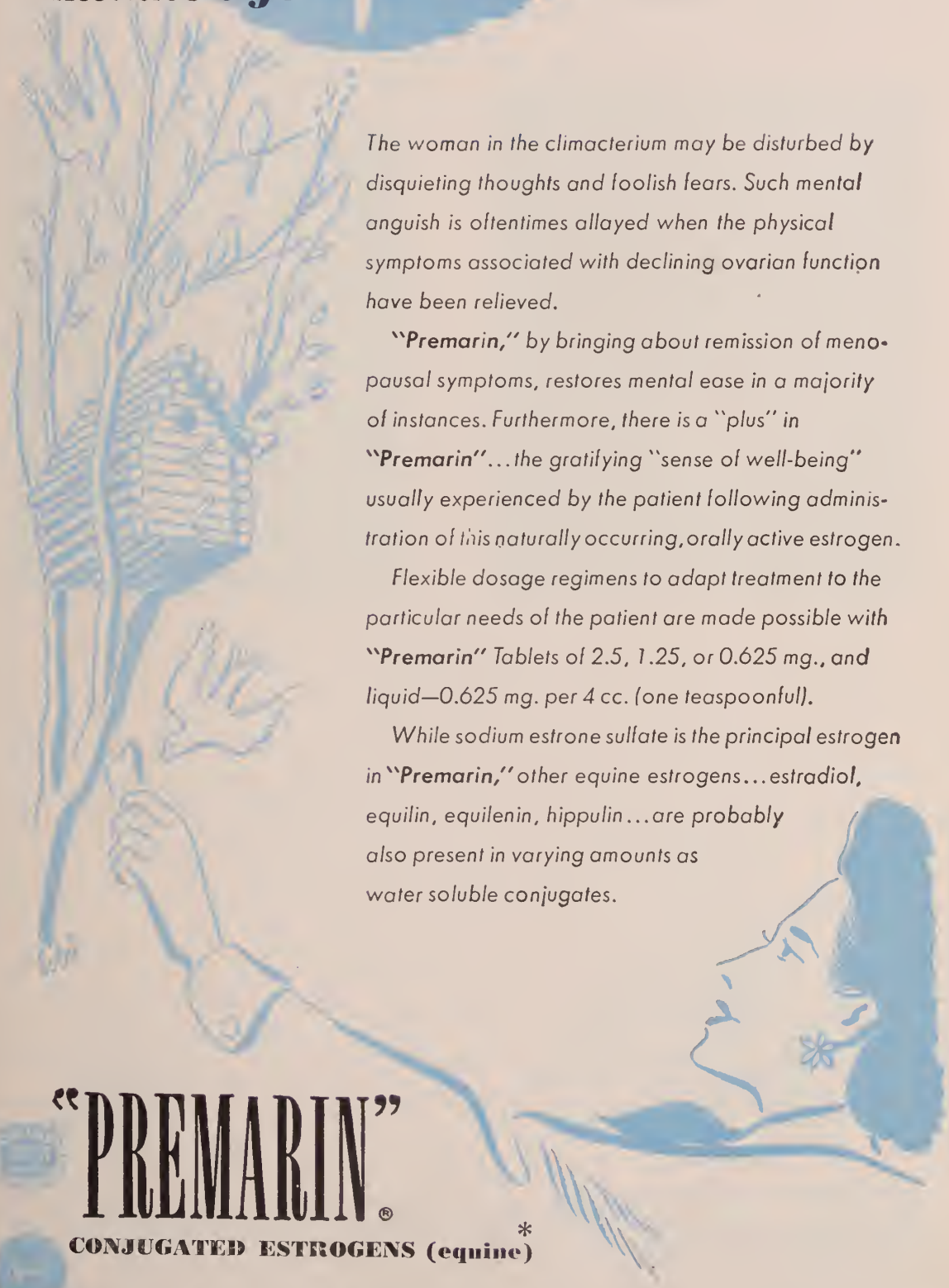
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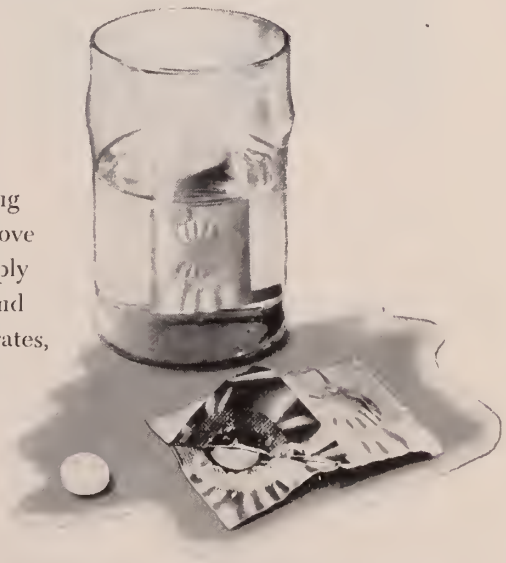
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1. Hoffman, W. S., and Volini, I. F.: Am. J. M. Sc. 213 520 (May) 1947

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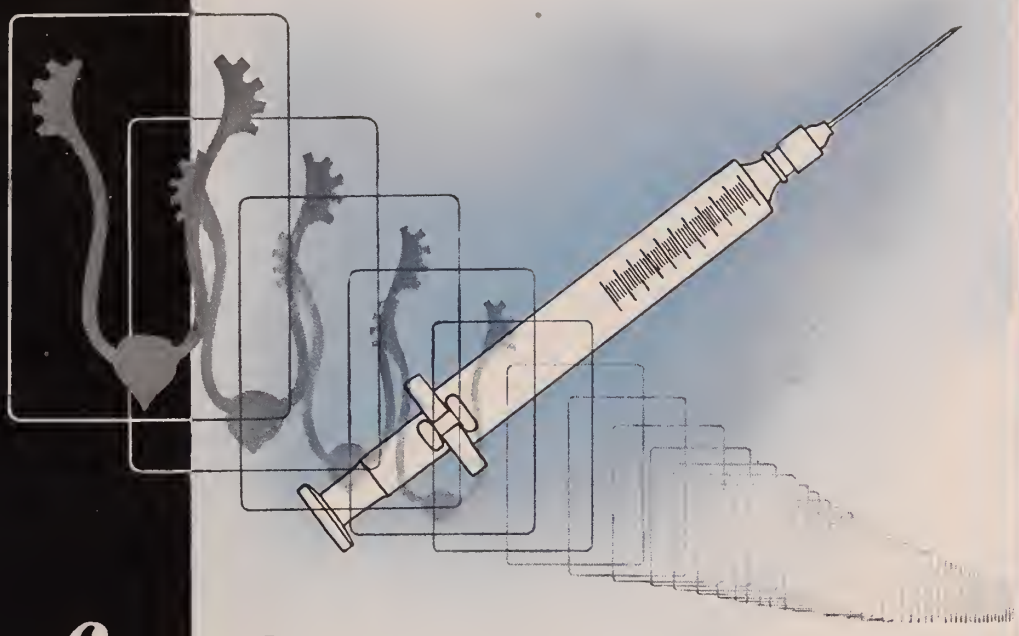
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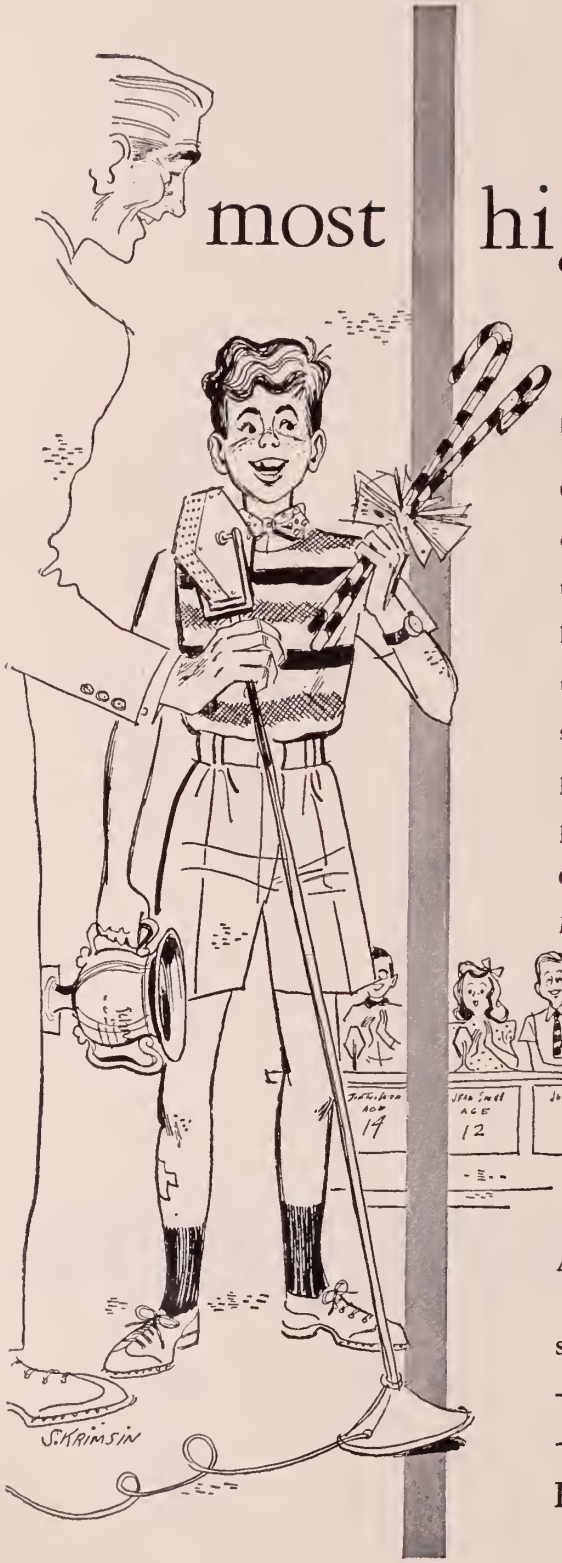
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THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION
PUBLISHED MONTHLY
Volume XXXV Jacksonville, Florida, October, 1948 No. 4

Hypertension: Recent Trends in the Surgical Treatment

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INTRODUCTION

The purpose of this paper is to outline the current role of surgery in the treatment of essential hypertension. Emphasis will be placed upon the selection of patients for operation, the various surgical procedures employed and the postoperative follow-up results. It is thought that this purpose can be most effectively fulfilled by reviewing the systems and results of several outstanding pioneers who have had a large experience with this type of surgery and who represent best the various poles of opinion within the subject. Accordingly, the following five authorities were selected for this study: (1) Peet, (2) Adson and Craig, (3) Smithwick, (4) Poppen and (5) Grimson. This paper is based upon the published reports of, and in some instances upon correspondence with, these surgeons. Brief reference will be made to my experiences.

SELECTION OF PATIENTS FOR SURGERY

Sympathectomy and splanchnicectomy are effective only in essential hypertension. Elevation of the blood pressure secondary to known organic lesions such as endocrine tumors and polycystic disease of the kidney is not benefited by these procedures.

In mild cases showing only a slight elevation of blood pressure and essentially normal optic fundi the prognosis is good with medical management.[1,2]

At the other extreme of essential hypertension one encounters patients afflicted with a high, fixed blood pressure, with pronounced sclerotic and degenerative changes in the ocular fundi and, frequently, with severe vascular disease affecting the heart, kidney or central nervous system. It is generally recognized that surgery is contraindicated in such cases as the operative mortality is relatively high and the end results poor.

Malignant hypertension is not regarded as a separate entity but as a severe and rapidly progressive form of essential hypertension. It may or may not be amenable to surgical treatment depending on how far it has advanced.

Having excluded the mild cases and those with irreversible hypertension, one is left with an intermediate group exhibiting moderate to severe hypertensive signs and symptoms. This remaining group is that in which the disease may be amenable to surgical treatment; so it is from this group that patients are selected for operation (fig. 1).

FIGURE 1

ESSENTIAL HYPERTENSION
Indications for Surgery

(1) Age under 50 years.
(2) Progressive hypertension.
(3) Adequate renal and cardiac function.
(4) Good sedation response.
(5) Stable personality.

While individual surgeons differ slightly in their criteria and methods of selection, they are in agreement in the main, and there is a tendency to be more conservative in an effort to improve end results and avoid fruitless operations.[1,3a,4a]

Nearly all surgeons agree that patients over 50 years of age are not good candidates for surgery.[5,6a] Patients under 40 years are preferred while the highest percentage of good results is obtained in those under 30 years of age.[3a]

Alcoholics, drug addicts and emotionally unstable patients offer a poor prognosis when subjected to operation.[6a] Although a previous cerebral accident does not in itself preclude surgery,[1] it should be regarded as a contraindication if hypertension continues to worsen and great changes are noted in other systems. Surgery should be abandoned if there is increased intracranial pressure.[6a] Patients giving a history of

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Read before the Florida Medical Association, Seventy-Fourth Annual Meeting, St. Augustine, April 11-14, 1948.

hypertensive encephalopathy are questionable candidates for operative treatment (fig. 2).

FIGURE 2

ESSENTIAL HYPERTENSION

Contraindications to Surgery

(1) Age over 50 years.
(2) Severe, fixed hypertension.
(3) Congestive heart failure.
(4) Renal failure (high N.P.N.).
(5) Recent coronary occlusion.
(6) Increased intracranial pressure.
(7) Addiction or emotional instability.

Progression of the hypertension is perhaps the strongest indication for surgical treatment. The duration of hypertension has little influence on the surgical results, providing the patient meets the requirement for surgery otherwise.[1]

The maximum systolic pressure compatible with a good operative result is around 250 whereas the maximum diastolic pressure is about 150 millimeters of mercury. The best surgical results are obtained in cases in which the pressures are considerably below these maxima. Smithwick[4a] thinks that a wide pulse pressure suggests a poor prognosis, and favors a relatively narrow pulse pressure in the patients to be treated surgically.

Considerable importance is attached to evaluation of the optic fundi. This aspect is the subject of another essayist on today's program.

An electrocardiogram and 7 foot heart roentgen study are essential as evaluation of the cardiac status of the patient is of great importance. The aorta should be carefully studied to rule out coarctation and to observe evidences of advanced arteriosclerosis.[4a] Enlargement of the heart, though undesirable, is not a contraindication to surgery. Previous coronary occlusion is not in itself a contraindication; however, a recent coronary occlusion or the presence of congestive heart failure should warn against operation.[1,6a] Anginal attacks make the prognosis unfavorable.[1]

As regards renal function, the urinary specific gravity (concentration test) should not be under 1.015 and the phenolsulfonphthalein excretion not less than 50 per cent in two hours.[4a] A blood nonprotein nitrogen of over 45 milligrams per hundred cubic centimeters should exclude operation.[1,3a]

A history of pyelonephritis is no longer considered a contraindication to surgery if the renal and cardiac functions are adequate.[4b] Pyelograms are essential as renal lesions so revealed may profoundly alter the therapeutic approach.[7] It is well known that in an occasional case hypertension is secondary to unilateral renal pathology. Nephrectomy is the proper approach in such cases. Then if the blood pressure does not fall, splanchnicectomy may be in order.

The lability of the vascular bed is evaluated by the cold pressure and sedation tests,[4a] the latter being of more prognostic significance. The sedation test consists of recording the blood pressure with the patient in bed under heavy sedation.

DIAGRAM OF THORACOLUMBAR SYMPATHETIC NERVE TRUNK, SPLANCHNIC NERVES AND RELATED GANGLIA

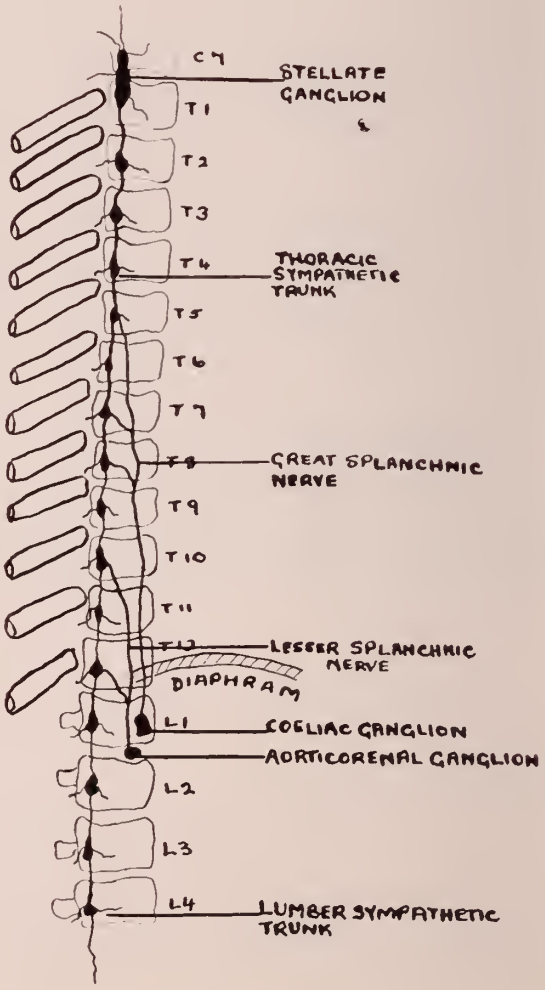


Fig. 3—A study of this diagram should orient one anatomically with the portion of the sympathetic nervous system which comes under surgical attack in the operations to be described. Only the thoracic and lumbar segments are shown. The view is of the right lateral aspect of the vertebra.

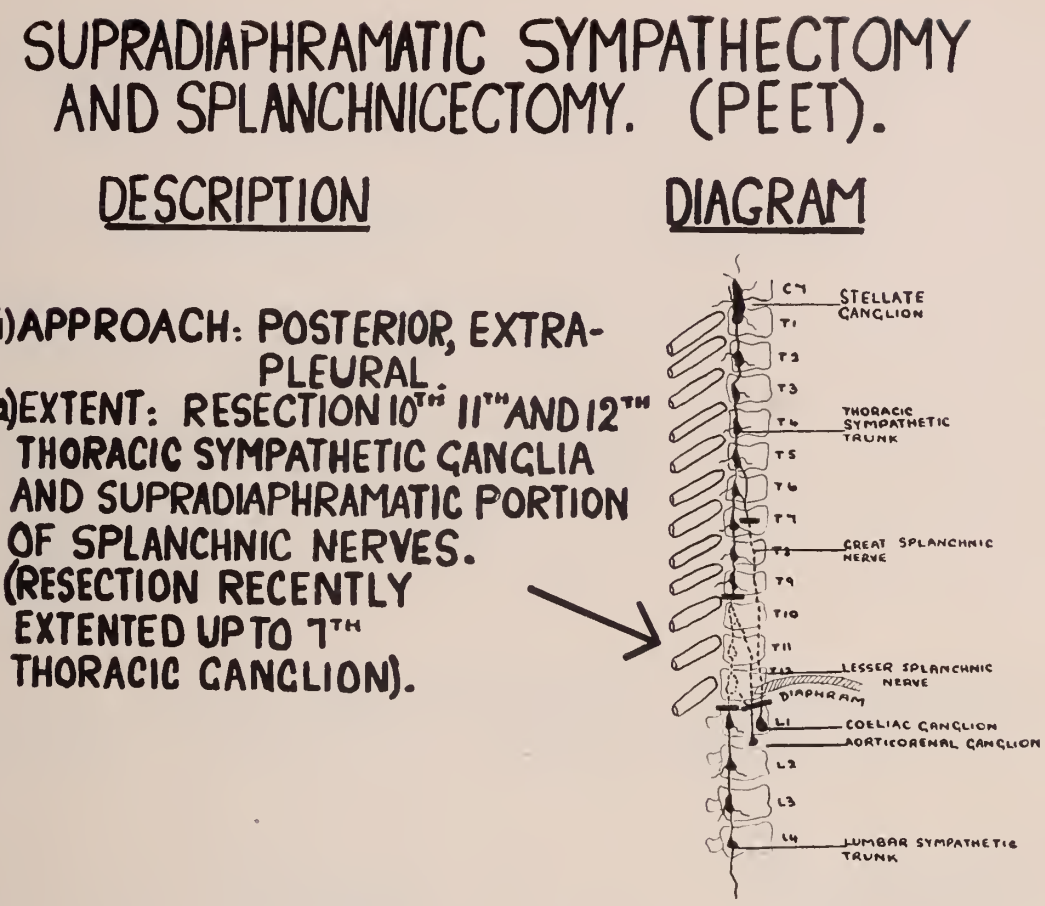


Fig. 4—This bilateral procedure is done in one stage and requires ten to fourteen days in the hospital.

If the pressure falls to normal under sedation, the prognosis with surgery is believed to be good. Failure of the pressure to drop is suggestive of a fixed hypertension. All aspects of each case must be carefully weighed before one comes to a decision regarding surgery since no single test yields a reliable prognosis. Every patient should first undergo an adequate trial of medical treatment.

The ideal surgical indication is exemplified by uncomplicated but progressive hypertension in a young and otherwise healthy person. Time and space do not permit presentation of the involved classifications which further segregate cases of essential hypertension on the basis of selection for surgery and postoperative prognosis.

SURGICAL PROCEDURES AND RESULTS

Because of the divergent views relative to the etiology of essential hypertension it is natural that a number of different surgical procedures have been devised. The common aim of all these procedures is the denervation of varying portions of the vascular bed by some form of sympathectomy and splanchnicectomy (fig. 3). They differ chiefly in two respects: (1) the surgical approach and (2) the extent of the denervation. It would seem of value to sketch the salient features and rationale of several of the operations most widely used today. An attempt will be made to summarize briefly the results reported to date by the surgeons whose operative procedures are reviewed. They will be grouped as good, improved and unimproved so far as possible. Such an overall summary is not accurate since the results have been reported in such a complex manner by the various surgeons. A good result indicates a fall in blood pressure to normal and freedom from symptoms. Patients improved show partial to complete relief and a fall in blood pressure but not to normal. Patients unimproved show no change in blood pressure or symptoms.

Peet[ab] evolved his bilateral supradiaphragmatic splanchnicectomy for relief of hypertension in 1933 (fig. 4). The procedure consisted of resection of the tenth, eleventh and twelfth thoracic sympathetic ganglia along with a generous segment of the great splanchnic nerve. The

rationale of Peet's operation is based upon his belief that essential hypertension is due to renal ischemia and that his procedure accomplishes denervation of the renal vessels and kidneys. He reported an operative mortality of 3.6 per cent.[3a]

In 1948, Peet,[3a] reporting his experiences with approximately 2,000 operations, presented the following results: 20.3 per cent good results, 46.7 per cent improved and 12.7 per cent of the living patients unimproved. Presumably the patients who died during the period of the follow-up are not included in these statistics. This author stated in this paper that he now extends his resection upward to include as high as the seventh and sometimes even the fifth thoracic ganglia.

The procedure described by Adson, Craig and Brown[8] was first performed by Adson in 1935 and is still the procedure of choice at the Mayo Clinic (fig. 5).[5, 9] It consists of bilateral resection of the first and second lumbar sympathetic ganglia and the subdiaphragmatic segment of the great splanchnic nerve.[8] These surgeons believe that essential hypertension is the result of generalized increased arteriolar tone and resistance. Their procedure is said to produce sympathetic denervation of the kidneys, adrenals, abdominal viscera and a portion of the lower extremities.[10]

Craig and Adson[10] reported their statistics in 1939 based on 237 cases. They reported 24 per cent good results, 28 per cent fair results and 48 per cent unimproved. There was no operative mortality. Recent reports on the work of these authors were not obtainable. In a recent personal communication, Adson[9] stated that at the Mayo Clinic more extensive sympathectomies were also being performed in order to compare the operative

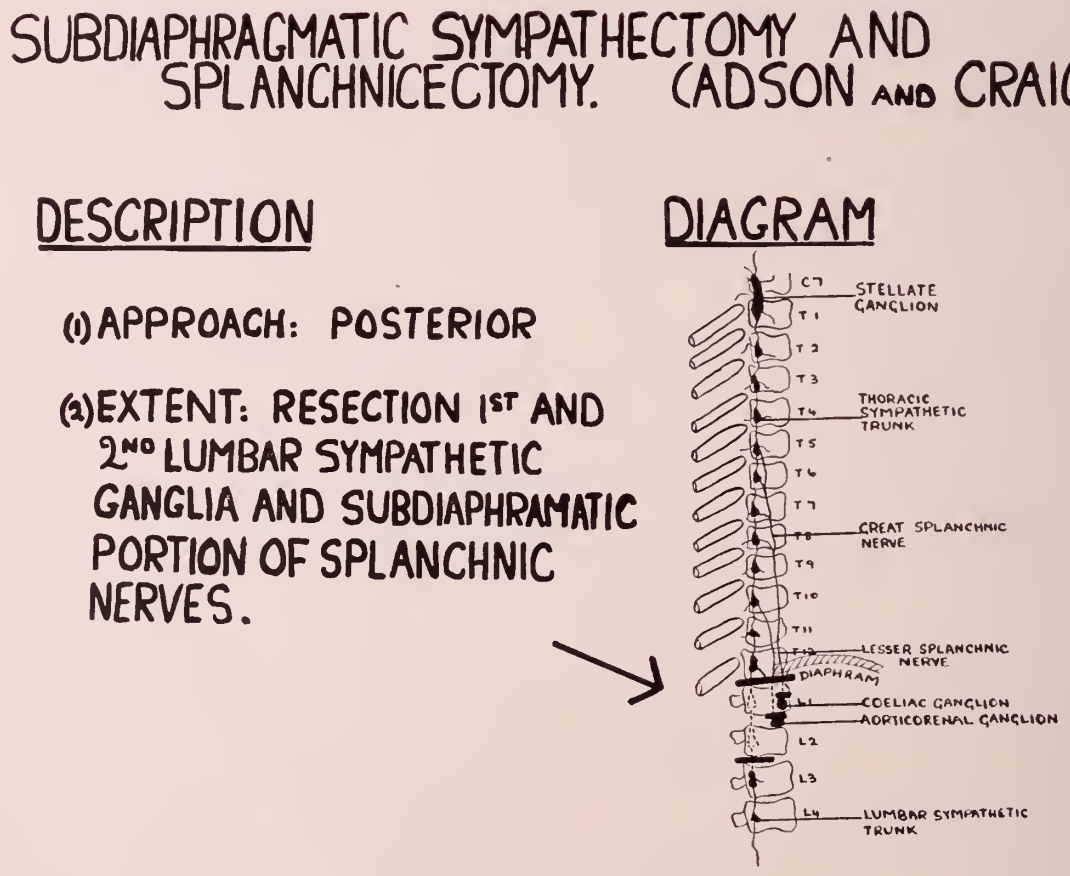


Fig. 5—This procedure has been advocated and practiced by the Mayo Clinic group.

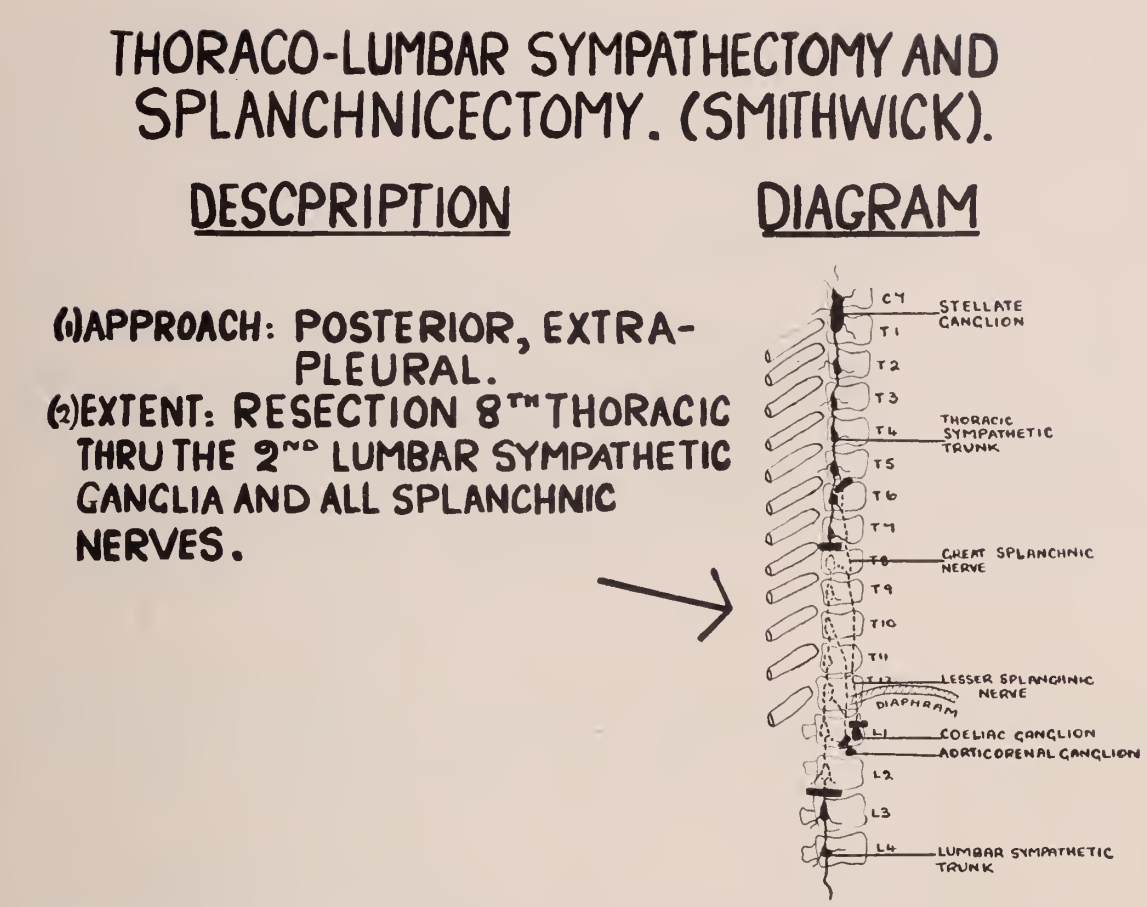


Fig. 6—This operation is employed more widely than any other over the United States today. It is done in two stages which are about eight days apart. The total hospitalization is from sixteen to twenty-one days.

results of the two procedures. He believes that more extensive sympathectomies are probably indicated in selected cases.

In 1940 Smithwick[4c] described the operation which bears his name (fig. 6). It consists of bilateral resection of the eighth thoracic through the first or second lumbar sympathetic ganglia along with the greater portion of the splanchnic nerve. This procedure is essentially a combination of the old supradiaphragmatic operation of Peet and the subdiaphragmatic operation of Adson and Craig. In 439 cases which Smithwick[4a] reported in 1947 the operative mortality was 2.4 per cent. He believes that increased peripheral resistance in the vascular bed is productive of essential hypertension and that sympathetic denervation of the splanchnic area is the most effective procedure in its treatment. Accordingly, splanchnic denervation is the chief aim of his operation.[4c] In cases in which the results are poor he sometimes performs more extensive secondary sympathectomies.[4a]

Follow-up studies based on the 439 cases reported in 1947 showed 65.8 per cent of the patients improved, 19.6 per cent unimproved and 14.6 per cent dead. No figure is given for those patients who maintained a normal blood pressure after operation, but I understand from other publications that it is about 25 per cent.[11]

Beginning in 1934 Poppen[12] employed the operation of Peet, turned to that of Adson and Craig in 1936[1] and combined the two in 1940.[1] In 1942[13a] he extended this latter operation and in 1947 described the even more radical procedure which he now prefers (fig. 7).[13b] It consists of resection of the fourth thoracic through the second lumbar sympathetic ganglia and all of the splanchnic nerves. Poppen[13b] places his operative mortality

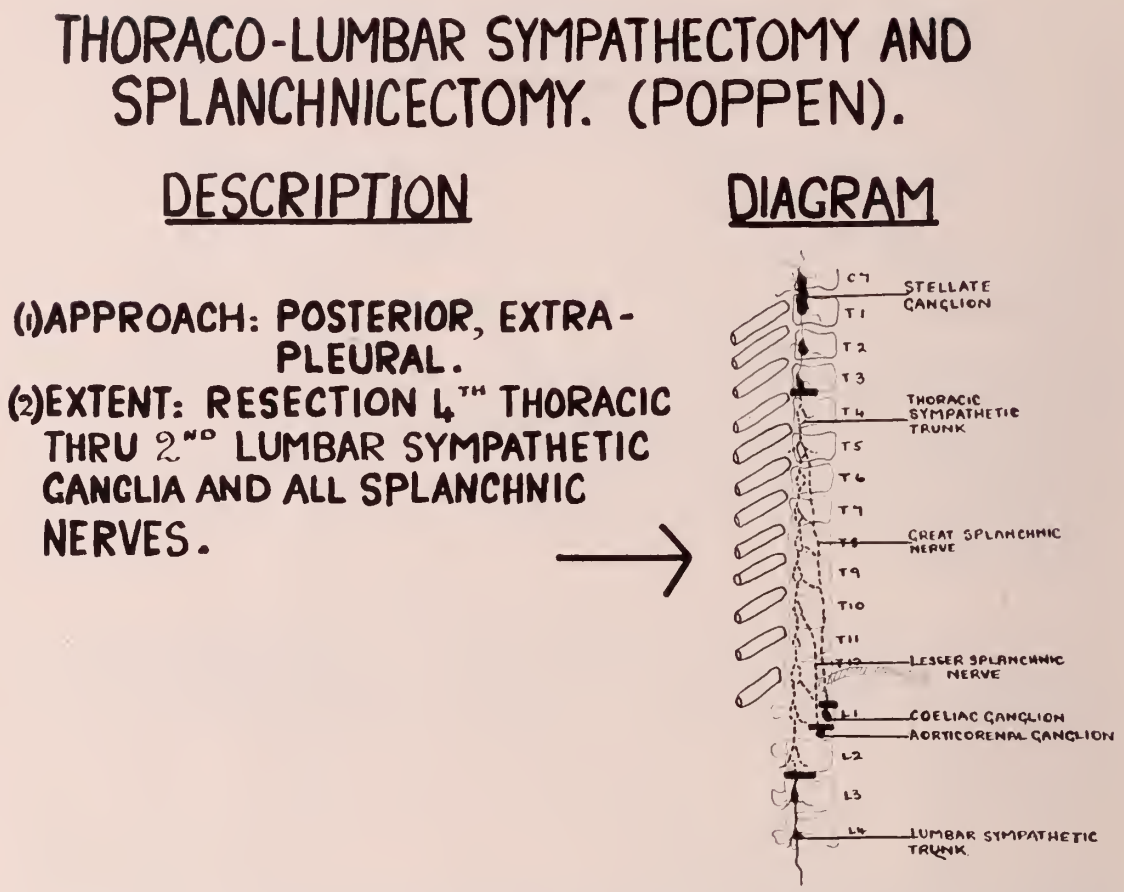


Fig. 7—Done in two stages a week or more apart, this operation requires about the same period of hospitalization as that of Smithwick. It is somewhat more difficult from a technical standpoint, but permits of a radical nerve resection.

at less than 0.5 per cent. He has become progressively more radical in an effort to improve his end results. He thinks that prolonged relief from hypertension is best obtained by an operation which, in addition to other effects, produces considerable postural hypotension through complete splanchnic denervation. He also thinks that sympathetic nerve regeneration is less likely following a radical resection.

In 1947 Poppen and Lemmon[1] reported experiences in 100 cases treated surgically. Follow-up results were good in 47 per cent, fair in 24 per cent and unsatisfactory in 22 per cent of the cases. Of the total number of patients, 71 per cent were improved.

In 1941 Grimson[6b] described an operation consisting of resection of the stellate ganglia, entire thoracic sympathetic chain, splanchnic nerves and the celiac ganglia (fig. 8). The first through the fourth lumbar sympathetic ganglia were included in the resection, which thus closely approached total sympathectomy. This procedure was based upon animal experimentation and the study of the various procedures employed in the treatment of hypertension by other surgeons at that time. This author has curtailed the operation recently to exclude the third and fourth lumbar ganglia from the resection in order to lessen the postoperative postural hypotension. He believes that the importance of splanchnic denervation has been overemphasized[6a] and that sympathetic denervation of the heart and upper portions of the body deserves equal attention.[6b]

In a recent personal communication Grimson[6c] stated that a preliminary survey of 97 patients reveals a good result in 38 per cent, a fair result

in 33 per cent and an unsatisfactory result in 14 per cent of the cases. The overall figure for patients improved is 71 per cent in this series. At the time of the survey 14.3 per cent of the patients were dead. The extensive operation advocated by Grimson[9b] was employed in all these cases. The operative mortality was 4.1 per cent.[6c] He believes that conservatism in the selection of cases for surgery will reduce the mortality considerably.

The foregoing statistics are based mostly on blood pressures. They therefore give an incomplete picture for there are many other aspects to be considered in the postoperative evaluation. Relief of symptoms such as headache and dizziness is of extreme importance and occurs in some cases when the blood pressure changes are slight or nil. Cardiac and renal functions may improve. Incapacitated patients may be rehabilitated so that they can resume work. Full success, however, must encompass a return of the blood pressure to normal as well as complete relief of symptoms. Only such an operative result as this will give the maximum prolongation of life and freedom from symptoms.

COMMENT

The five year survival rate of patients treated surgically has been found to be more than twice that of patients with comparable disease treated medically.[3c,11] The comparison is even more striking in malignant hypertension, which is universally fatal in cases treated medically while Peet[3c] obtained a 21.6 per cent five year survival rate in this type of hypertension when surgery was employed. Similar figures have been reported by others. These comparisons present a strong argument in favor of operation in suitable cases.

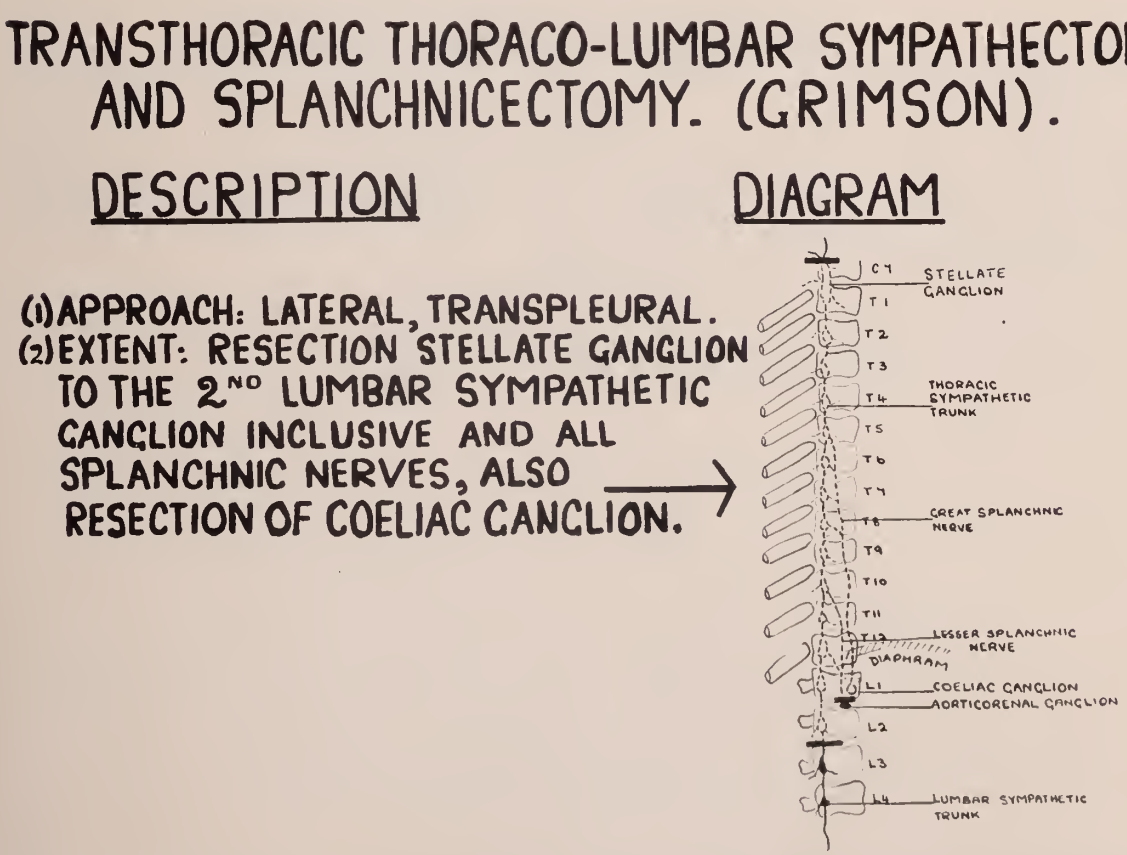


Fig. 8—This is the most extensive of the routinely performed operations employed today. Grimson obtains his exposure by means of two transthoracic incisions, one through the bed of the third rib high in the axilla and the other through the bed of the tenth rib posterolaterally. A bilateral Horner's syndrome is produced by removal of the stellate ganglia. The overall end results are good.[9c]

An effort should be made to distinguish between mild cases and the early stages of more serious disease since cases of the latter type should receive the benefit of surgery before the blood pressure has become excessively high and resultant vascular damage has occurred. Mild cases are characterized by a systolic pressure ranging between 150 and 180 and a diastolic pressure from 90 to 110 millimeters of mercury which pressures show no tendency to rise further when the patients are observed over an extended period. The pressure approaches normal with rest in such cases. When on repeated examination the trend of the blood pressure is progressively upward, one can predict with considerable accuracy that in such a case the patient is heading toward a dangerous and incapacitating hypertensive state. The most brilliant surgical results are obtained when patients of this latter type are operated upon before the disease is full-blown.

Conservatism in the selection of patients for operation will greatly increase the percentage of good results and minimize the number of complete failures. Although the criteria for such selection are not precise, a rather accurate prognosis can be made after careful study of all aspects of the case. The tendency to operate upon a patient with an unfavorable prognosis "because it offers him his only chance" should be discouraged. In most of such instances the patient suffers pain and expense and obtains no relief from his disease. Unless, by the criteria in present use, a patient has at least a reasonable chance for a successful result, the inevitable should be faced and the patient carried along in the best way possible on medical treatment.

One fact stands out from the preceding re-

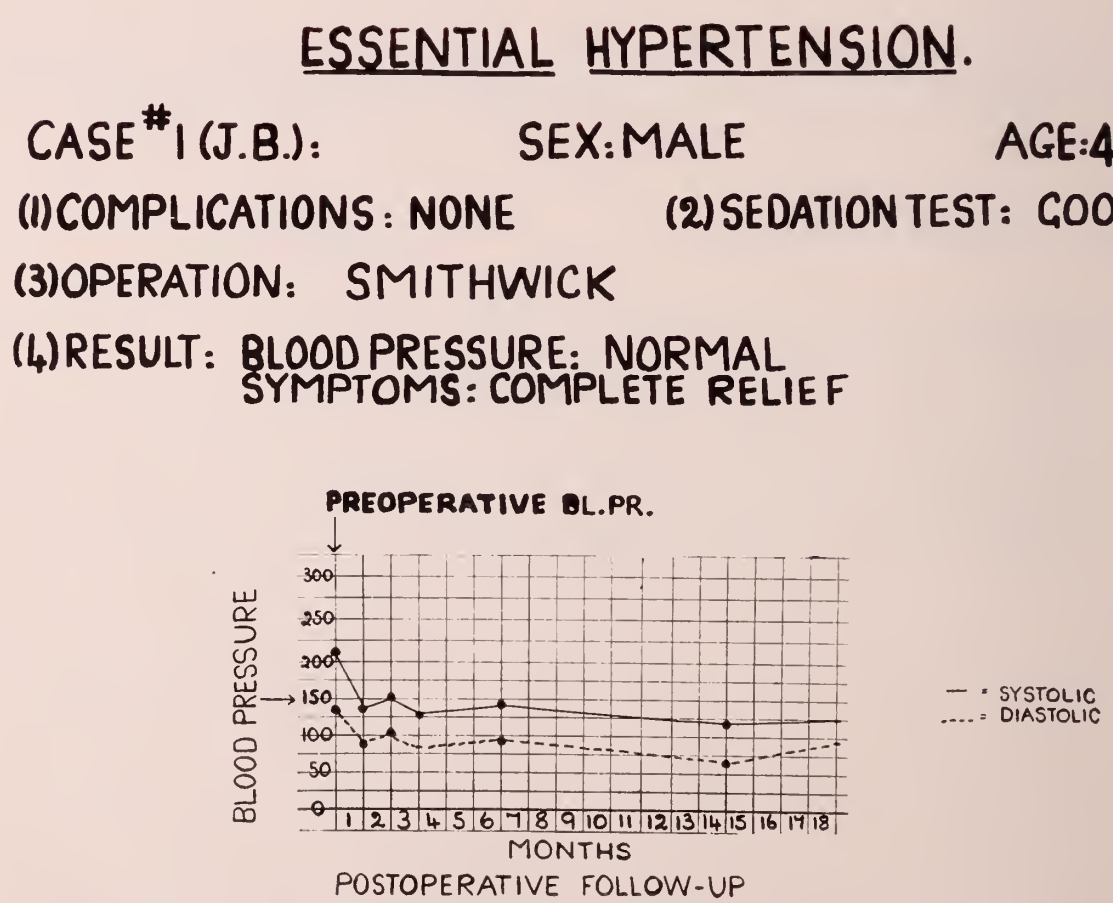


Fig. 9—This patient had had hypertension for fifteen years. He carries on normal activity and has a busy and responsible position in business. The result is an excellent one.

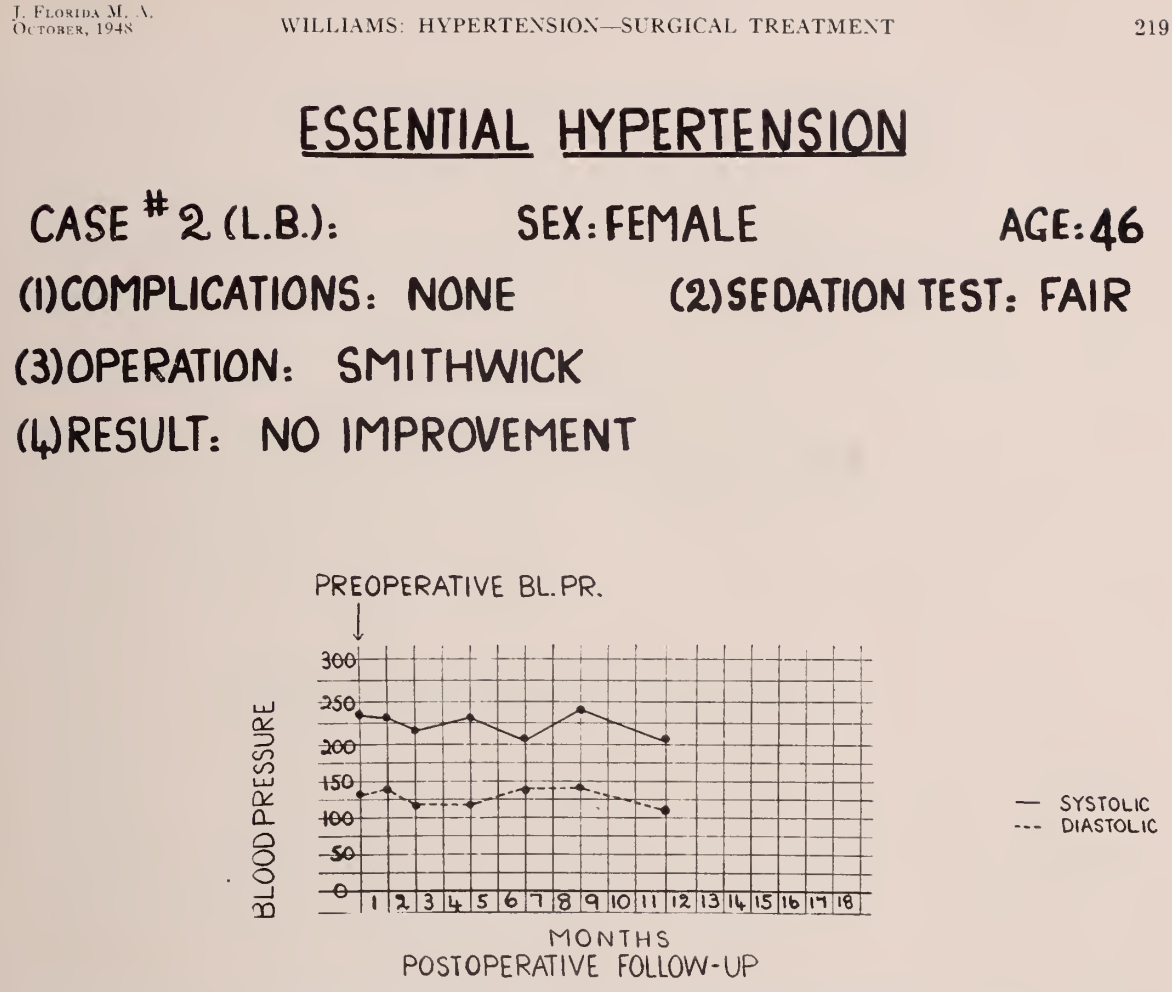


Fig. 10—Arteriosclerotic vascular changes and a very severe grade of hypertension are responsible for this failure. The patient is still alive but suffering from headache and other distressing symptoms.

view. No investigator has finally determined how extensive the sympathectomy should be to give a maximum good result in the average case. The problem resolves itself, therefore, into one of determining which operation will be most effective in the greatest number of patients for an extended period of years. Only a patient study of end results will eventually provide the answer. Present statistics indicate that the more extensive operations of Poppen and Grimson offer a higher percentage of good results than the lesser procedures of Peet, and Adson and Craig. The trend of all surgeons has obviously been toward more extensive denervations with the hope of improving the end results. Poppen[13b] has shown that radical denervation can be done without increasing the operative mortality. Grimson[9a] has aptly stated that "lowering of blood pressure is directly proportional to the extent of the sympathectomy and inversely proportional to the severity of the disease." The surgical approach is of secondary importance and had best be selected to suit the skill and individual operation of the surgeon concerned. I have pointed out that many operators advocate some type of extrapleural approach while others have found the transpleural route preferable.

My personal experience is limited to 11 cases. The Smithwick operation was employed in the first 4 and more extensive transthoracic resections in the last 7 cases. Follow-up shows 4 cases with good results, 2 improved and 2 with no benefit. There was 1 death, which occurred suddenly two days after the second stage operation and was apparently due to cardiac failure. The stellate ganglia were included in the resection in this

case. The patient had previously suffered a coronary occlusion and an episode of hypertensive encephalopathy and was a poor candidate for surgery. In the remaining 2 cases there have been normal blood pressures since operation, but the follow-up is too short for them to be significant. Examples typical of these various types of results are illustrated in figures 9, 10, 11 and 12.

The operation which I am at present employing resembles the Grimson procedure. It is done in two stages through a transthoracic approach (fig. 13). The stellate ganglion is spared, but all its connections are severed except that with the cervical sympathetic chain (fig. 14). The sympathetic trunk is then resected from the lower pole of the stellate ganglion (first thoracic ganglion) through the first lumbar ganglion and all splanchnic nerves excised. This provides an extensive denervation, but does not produce a Horner's syndrome which of course occurs if the stellate ganglion is excised. The stellate and celiac ganglia have not been removed routinely. It is thought that further experience with this aspect of the operation is necessary to determine whether resection of these ganglia should be advocated in every case.

I am pleased with this operative procedure to date. The exposure permits of a very radical nerve resection, as has been noted, but carries no more morbidity than the more or less standard procedure of Smithwick. The patient

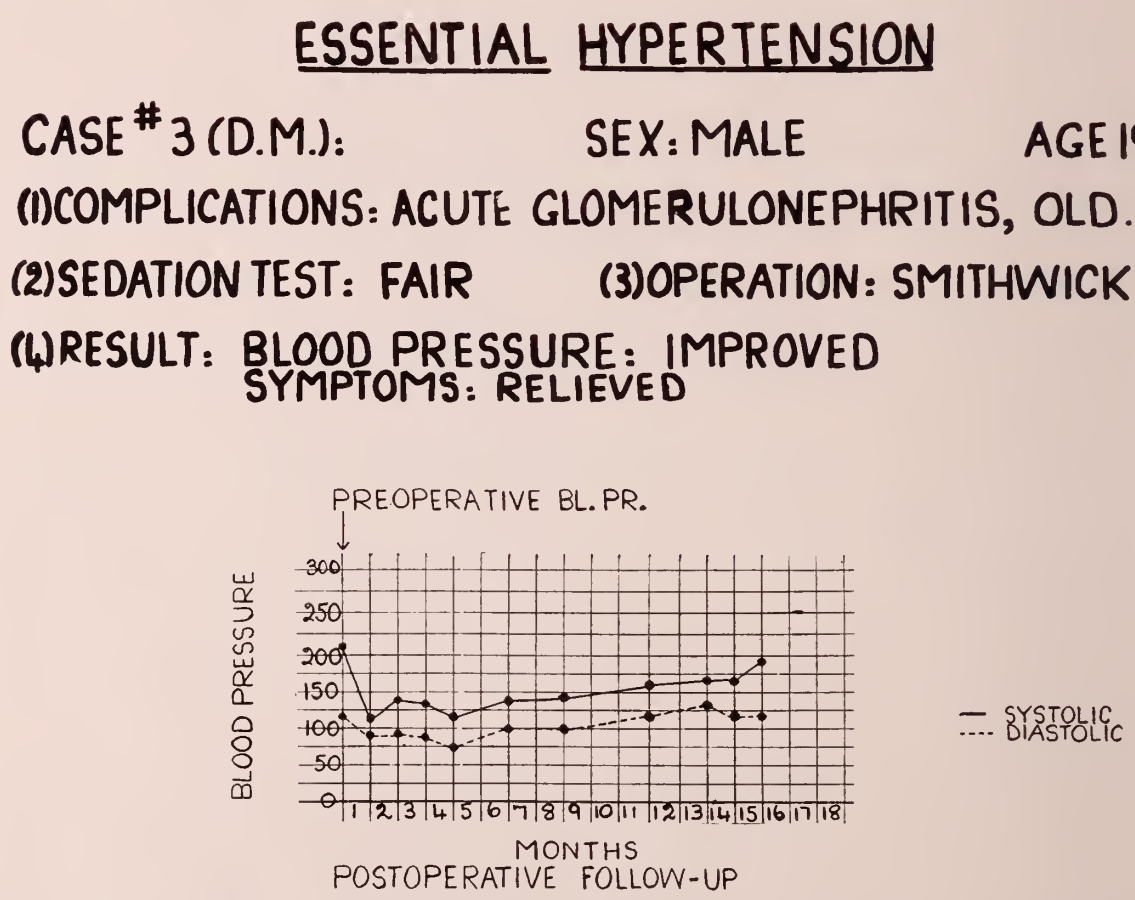


Fig. 11—This patient obtained a good response for six months following operation. He then noted a return of headaches, though not severe. There was a corresponding elevation of blood pressure, though not to preoperative levels. Further surgery is contemplated with the hope of relieving the hypertension permanently. This patient works hard during the day and goes to school each night.

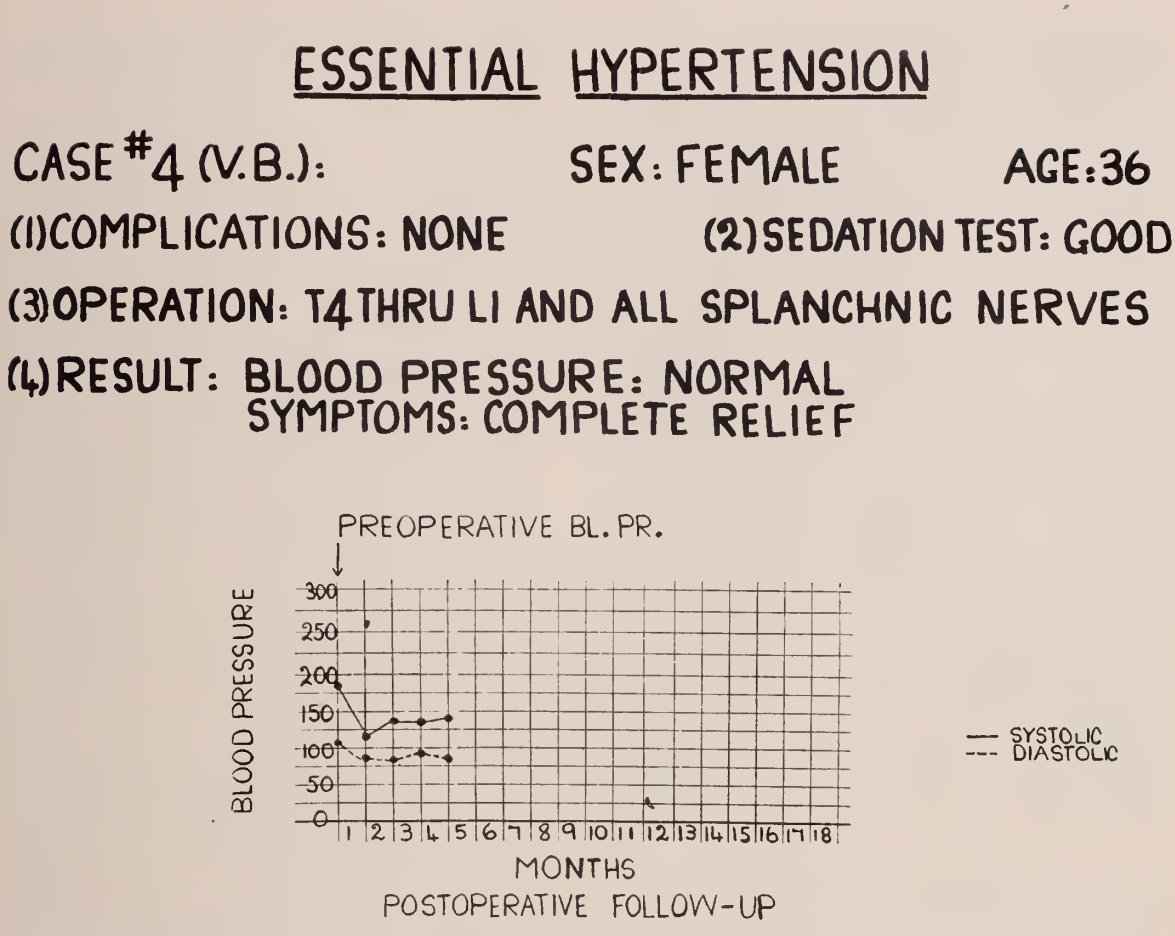


Fig. 12—The surgical approach was transthoracic in this case. This patient is high-strung and more active than average. The result has been excellent to date.

is hospitalized from six to ten days for each of the two stages and is sent home for three weeks between operations. Transient pleural effusion is common during the first week after surgery, but there has been no instance of wound infection or empyema.

A skillful, resourceful and thoroughly trained anesthetist is essential if splanchnicectomies are to be done successfully and safely. Different operators and anesthetists use different technics according to their preferences and abilities. We employ endotrachial anesthesia in every case, using nitrous oxide, cyclopropane, ether and oxygen in various combinations. Intravenous pentothal sodium accomplishes a quick induction and, in conjunction with the agents named, affords a supplementary action throughout the operation. Sudden drops in the blood pressure are common during the operation. They are combated with neosynephrin and transfusions of blood and plasma. One cannot overestimate the premium to be placed upon the services of a competent anesthetist during operations of this sort in which so much depends on good judgment and prompt action. Through being critical in the selection of patients and employing the somewhat radical operation just described I hope that the end results will be gratifying.

SUMMARY AND CONCLUSIONS

The criteria for the selection of patients for surgical treatment have been reviewed. The procedures of (1) Peet, (2) Adson and Craig, (3)



Fig. 13—This patient is shown sixteen days after the first stage operation. The location of the incisions and transthoracic approach are modeled upon the procedure of Grimson. The operating time for each stage is between two and three hours.

Smithwick, (4) Poppen and (5) Grimson have been briefly presented. The end results of these authorities have been summarized.

Recent trends in the surgical treatment of hypertension are: (1) more rigid criteria for the selection of cases for surgery; (2) a general tendency toward more extensive sympathetic denervations; and (3) a noticeable improvement in follow-up results as a result of (1) and (2).

Brief reference is made to my experiences in this field, and a series of 11 cases is reported.

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TRANSTHORACIC THORACO-LUMBAR SYMPATHECTOMY AND SPLANCHNICECTOMY. (TENTATIVE MODIFICATION).

DESCRIPTION

(1) APPROACH: LATERAL, TRANSPLEURAL.
(2) EXTENT: SECTION MEDIAL AND LATERAL CONNECTIONS OF STELLATE GANGLION. RESECTION 2ND THORACIC THRU 1ST LUMBAR SYMPATHETIC GANGLION AND ALL SPLANCHNIC NERVES.

DIAGRAM

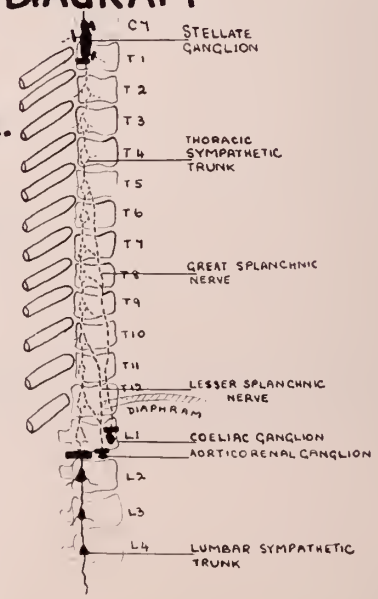


Fig. 14—This procedure, a modification of the Grimson operation, is employed by me at present. Results have been excellent to date, but final evaluation will require a longer follow-up and a much larger series of cases.

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This is the third of four papers on "Hypertension" presented at the St. Augustine Convention. The first appeared in the August issue.

Discussions of the entire symposium will be published at the end of the fourth paper.

Dacryocystorhinostomy

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LAKELAND

Dacryocystorhinostomy is one of the most successful operative procedures. Oddly enough it was slow to be generally accepted even after its value was fairly well proved. It was first reported by Platner[1] in 1724. Following this early start little was done with the operation until Toti[1] published his technic in 1904. West[1] reported his intranasal operation in 1911. Ohm,[1] in 1912, was the first to suture flaps of mucosa to each other. Dupuy-Dutemps and Bourguet[1] described their procedure in 1920. In 1926 West[2a] reported 1,600 operations with 90 per cent cures. Several other large series had been reported by that time, always with a high percentage of cures. In spite of these successes the profession was slow to adopt the advance. Until a few years ago, in leading medical centers more tear sacs were being removed than were being subjected to dacryocystorhinostomy. It is likely that part of the delay in acceptance of the procedure was caused by the confusion created by rival claims of superiority of the intranasal operation on the one hand and the external approach on the other. Perhaps another reason has been the apparent technical difficulties in carrying out the operation. Whatever the cause of the delay, that period is certainly past.

The tremendous advantages the anastomosis operation enjoys over the older method in which the tear sac is removed are well established. The operation in most instances re-establishes normal drainage of tears from the conjunctival sac and removes a storehouse of chronic infection. West[2b] in 1931 with cultures showed that pathogenic bacteria disappear from the lacrimal sac in two or three days after operation. He also cited Mattice[2b] of the Axenfeld Clinic, who found pneumococci in 43 per cent of cases after extirpation of the lacrimal sac, some as long as several years afterward.

The major indication for the operation is obstruction of the lacrimal passages at the lower portion of the lacrimal sac or in the nasolacrimal duct. Other indications are after trauma or after dacryocystectomy; if part of the sac remains, the operation can still be done. If only the canaliculi remain, the ends can be implanted into the nose. There are no age limits, good results being reported from 4 to 76 years.

Read before the Florida Society of Ophthalmology and Otolaryngology, St. Augustine, April 11, 1948.

Contraindications are malignant disease of the sac or incurable disease of the sac such as tuberculosis or actinomycosis. Other conditions which do not contraindicate operation but should cause it to be postponed are acute dacryocystitis and extensive nasal disease. These conditions should abate before operation is done. It has been stated that the intranasal operation can be done when the sac is acutely inflamed. This might be considered one advantage of the intranasal technic.

The most commonly used operations are:

1. The West intranasal operation or its modifications. In this operation the lateral nasal wall adjacent to the lacrimal sac is removed by an intranasal approach. After exposure of the medial aspect of the sac, this wall of the sac is removed, allowing it to open into the nose. Frequently an intranasal operation must be preceded by a submucous resection and removal of the tip of the middle turbinate. Most writers express the belief that this type of operation is more apt to fail than the external operation with suturing of flaps because of early closure of the opening by granulation tissue or later bony closure.

2. The Toti-Mosher operation, in which the approach is through an external or skin incision. A bony opening is made into the nose medial to the sac, and the nasal mucosa and medial wall of the sac are removed in this area.

3. Transplantation of the severed end of the sac is another popular method. The sac is cut at the junction with the nasolacrimal duct, and the cut end is carried through an opening into the nose. Gifford,[4] at the meeting of the American Academy of Ophthalmology and Otolaryngology last fall, reported 103 cases in which the operation was performed by this method. In 78 per cent this procedure was successful, in 9.5 per cent it was partly successful, and in 13.5 per cent it was a failure.

4. Probably the most widely used of all tear sac operations is the Dupuy-Dutemps procedure. The anesthetic of choice is intravenous pentothal sodium. Local infiltration anesthesia combined with topical anesthesia in the nose is extensively used. I have used local anesthesia, and the operation can be done painlessly this way, but the method is not without disadvantages. The amount of hammering with mallet and gouge is considerable because the first opening is made in the thick bone of the anterior lacrimal crest. Most patients prefer to be asleep at the time the mallet and gouge are being used. In small children ether anesthesia is used, and the anesthetic is given through a catheter. After the patient is asleep, the nose is packed with gauze on the side to be operated upon.

The skin incision begins just above the level of the inner canthus and passes straight down for about 2 cm. along the border of the anterior lacrimal crest. Most descriptions call for a curved incision. There is no advantage in a curved incision, and if one uses a subcuticular stitch, the straight incision is much better. The first incision is down to the bone of the nose. From there it is an easy matter to elevate the periosteum down into the lacrimal fossa. This procedure automatically locates the sac. The field is kept free of blood by the use of a nasal or brain suction tip and by ligation of larger vessels. Later in the operation when the nose is entered, the field should be dry. Not infrequently there is troublesome bleeding from the nasal mucosa. This can often be stopped by packing a small pledget of one of the new absorbable hemostatic agents[1] against the bleeding point. Care must be taken not to traumatize the mucosa by sucking the flaps into the end of the suction tip.

The work on the sac can usually be done below the level of the inner canthus without cutting the canthal ligament. If cutting the ligament is necessary, this is done without fear of after-effects, but care is taken to resuture the ligament in the proper position. The initial opening in the bone may be made with a burr, but it has been observed that the nasal mucosa is much more likely to be torn by this method. The bony opening is enlarged with a Kerrison or Citelli rongeur. The window should be 10 to 15 mm. horizontally and 15 to 20 mm. vertically. This is roughly the size of an elongated dime. If there is more room, it should be made larger. The opening should extend down and forward as much as possible. This direction will promote better drainage through the new passages and keep the operation away from the middle turbinate and ethmoid cells. Vertical incisions are made in the lacrimal sac and nasal mucosa. Horizontal cuts are made at each end of the vertical incisions so that completed openings have the shape of a capital I. The posterior nasal and sac flaps are joined with two interrupted size 000 catgut sutures. The anterior nasal and sac flaps are united in a like manner except that it is well to catch

in this suture some fascia at the upper and lower poles of the incision just under the skin. This, when the incision is closed, draws the anterior mucosa forward insuring immediate patency of the new channel. The skin is usually closed with interrupted black silk sutures, and a pressure bandage applied. Half of the sutures are removed in forty-eight hours and the remainder in seventy-two hours. No suture scars result. A subcuticular stitch may be used instead if desired.

Penicillin is given subcutaneously for two to three days postoperatively. The wound heals with much less tissue reaction than when penicillin is not used. The dressing is left off after three to four days, and the patient is given penicillin solution to use as eye drops every three hours. The lower punctum is irrigated on the third or fourth day and again in a week. There is no other postoperative care unless complications develop. Usually if there is a failure, it is evident in a week.

Reported results vary somewhat, but in all series are consistently good. In one of the smaller series, that of Ayuyao and Yambao,[5] 27 cases were reported with 100 per cent success. Hallum[6] reported 50 odd cases with only 2 failures for a record of 98 per cent successes. Averback and Ivanova[7] reported 1,200 cases in 95 per cent of which there was relief from pus and mucus and in 96 per cent relief from tearing. From an extensive review of the literature the percentage of success is consistently higher in the operation in which anterior and posterior mucosal flaps are sutured together. In my small series of 10 cases there have been no failures. In another small series with which I was associated there was 1 failure and this was due to faulty operative technic. One cause of variation in results reported in different series is a lack of uniform criteria for judging success. Hughes, Guy and Bogart[8] pointed out that judgment of success or failure should be based on four points: 1. Clinical relief of symptoms. 2. Physiologic instillation test, in which stain such as fluorescein put in the conjunctival sac appears in the nose in ten to twenty minutes. 3. Irrigation test, in which fluid passes into the nose with irrigation. 4. Successful irrigation only after probing.

The most frequent causes of failure are: 1. Incorrect diagnosis. Care should be taken not to operate in cases of epiphora that result from some cause other than obstruction of the lower part of the lacrimal passages. In cases with tearing arising from other causes such as eversion of the lacrimal punctum cure will not be effected by dacryocystorhinostomy. 2. Faulty operative technic. Late closure is avoided by use of a large bony window and by sutured flaps of mucosa. An improperly placed window will not promote drainage as well and is apt to cause difficulty at the time of the operation, such as getting into ethmoid cells or the middle turbinate. Postoperative tissue reaction and granulation tissue formation are less when penicillin is used after the operation. In other cases failure can be avoided by not operating in the presence of too much pathologic change within the nose, preferably waiting until that condition has been corrected.

CONCLUSIONS

1. Dacryocystorhinostomy should always be done instead of dacryocystectomy except in rare instances.

2. The operation is successful in a high percentage of cases when performed well by any of several methods.

3. Most authors prefer and report better results with an external operation in which sutured mucosal flaps are used.

4. The operation can be performed by any capable eye, or ear, nose, and throat surgeon.

SUMMARY

The history of the development of dacryocystorhinostomy is given. Indications and contraindications are described. The most commonly used operations are listed and the Dupuy-Dutemps procedure is described. Results in several series are summarized. Causes of failure are discussed.

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Box 1133.

DISCUSSION

DR. WALTON B. WALL, JR., Orlando: Dr. Hester is to be congratulated on presenting a thorough description of this valuable operation. My experience with it has been rather limited. I have used this operation three times. In 2 cases there was relief of epiphora, and in 1 there was not. I think the reason for no relief in this case was that the obstruction was too high in the sac to permit adequate juncture of the nasal and lacrimal mucous membrane.

A thorough diagnostic study of the puncta, canaliculi, size of the sac, level of the obstruction and condition of the nose cannot be overemphasized. Obviously if the puncta or canaliculi are obstructed or in malposition, the operation will not offer relief. The level of the obstruction in the sac can be determined by gentle probing or by the use of roentgen studies after lipiodol instillation. The nasolacrimal duct runs in such a narrow channel and fibrous tissue is laid down so early that probing repeatedly or vigorously is usually a painful, useless procedure and is to be condemned.

Obstruction of the lower end of the duct may be caused by pressure of nasal polypi, hypertrophied inferior nasal turbinate bone, extreme deviation of the septum and chronic rhinitis. Anatomically the sac itself slopes gently outward while the duct to the nose inclines inward. At this point of junction there is an angulation as well as a constriction, and it is here that obstruction usually occurs. The wall between the sac and the ethmoid sinuses is thin, and thus an ascending infection from the nose or sinuses will soon involve the nasolacrimal mucosa and clog the duct with stricture formation.

Immediate postoperative results are almost invariably better than the final results. I believe that one should carry his postoperative observation at least three years before deriving a conclusion.

Postoperative washings with sulfathiazole solution have been reported of value. Sometimes a postoperative inflammatory connective tissue blocking will be prevented. If a connective tissue blocking of this nature does occur, a second operation is indicated.

DR. THOMAS M. EDWARDS, Tampa: It is a pleasure to discuss Dr. Hester's comprehensive paper. When I first examined his summary, which he kindly sent me, I thought there would be little that I could add; however, I should like to give the rhinologist's viewpoint.

I consider this condition a rhinologic one with ophthalmologic symptoms. As you know, there has been a great deal of rivalry between rhinologists and ophthalmologists in the care of this condition. Diggler, in a series of 120 cases, found all causes to be intranasal. A common cause of this condition is trauma, such as nasal fractures, nasal operations, antrum windows improperly placed and antrum punctures. Another is coagulation of the inferior turbinates. A colleague recently injected an inferior turbinate with sodium morrhuate, with resulting obstruction to the duct. Tumors of the nose and antrum, including nasal polyps, gumma, atrophic rhinitis and ethmoiditis are other frequently mentioned causes.

I believe if many of these intranasal conditions were properly treated, the operation would be unnecessary. In regard to the operation of choice, I disagree with the present company in that I think the intranasal operation is to be preferred. In my opinion its lack of popularity is due to the fact that the ophthalmologist, doing the operation, is not familiar enough with intranasal technic to perform it successfully. The intranasal operation has several advantages. First, it leaves no external scar with possible keloid formation; second, it does not injure the musculature of the eye; third, the middle turbinate is more easily preserved; and fourth, there is no possibility of fistula formation.

I enjoyed Dr. Hester's paper and think that closer cooperation between ophthalmologists and rhinologists will lead to a better handling of this problem.

DR. CARL S. MCLEMORE, Orlando: I should first like to commend Dr. Hester on his excellent presentation of the Dupuy-Dutemps method of treating chronic dacryocystitis. Since 1936, at which time Dr. Elmer Whitney and I reviewed three hundred and fifty papers pertaining to this subject, I have adhered to the dacryocystorhinostomy procedure essentially as described by Toti and Mosher. The Dupuy-Dutemps method is no doubt an improvement as the wall of the lacrimal sac is actually sutured to the mucous membrane of the nose. In the case of a large mucocele type sac this should not be at all difficult; however, in the case of a small sac I should think it might be quite difficult. It has been my practice to leave a silver wire in place for about ten days, thereby insuring an epithelial-lined fistula into the nose.

The use of a mixture of lipiodol and barium has been helpful in visualizing the sac and determining the point of obstruction. The procedure is simple and in my opinion well worth while. If this study reveals the obstruction to be in the nasolacrimal duct, the dacryocystorhinostomy is the procedure of choice.

Anyone doing this type of operation should be cognizant of the agger nasi cells, for when present they overlie the nasolacrimal duct, and when infected often involve both the tear duct and tear sac. Creation of a fistula through these infected cells may result in a failure of the operation and may also encourage spread of infection to the eye.

In closing I should like to thank Dr. Hester for bringing this most interesting subject to us and also for the opportunity of seeing his motion picture of the operative procedure.

DR. W. JEROME KNAUER, Jacksonville: I have certainly enjoyed Dr. Hester's paper and believe the operation he has presented here is the one of choice. As to the discussion of recurrence of symptoms after the operation, I recall at least 2 patients whom I have been able to follow over a period of three years who are well and have had no subsequent trouble.

DR. S. B. FORBES, Tampa: I appreciate Dr. Hester's excellent paper. This operation is not, however, as simple as the description given. To me one of the especially important points is to go through the thin bone in the lacrimal fossa and come forward into the frontal process of the maxilla with a rongeur. In this way excessive use of the chisel and hammer is avoided. I think the crux of the suturing is in the use of the special lacrimal atraumatic needle with No. 000 chromic catgut. The needle is so small and of such curvature that it is rather easy to handle.

DR. HESTER, concluding: I thank the discussors for the many interesting points brought out.

I heartily agree with Dr. Wall that repeated or vigorous probing is to be condemned. It has been my practice to probe gently once or twice and if this is unsuccessful to go ahead with surgery.

Dr. McLemore points out that agger nasi cells are sometimes present and overlie the nasolacrimal duct. I should wait for this condition to present itself before changing the method of operation. I am opposed to the routine curettement of this area of the nose. Every effort should be made to preserve the nasal mucosa to form flaps. This will insure adequate and early formation of an epithelial lining for the new tract. If the bony opening is made sufficiently far forward and downward, complicating nasal structures will in most cases be avoided.

Electroshock Therapy

James Benson O'Connor, M.D.
CHATTAHOOCHEE

Since the introduction of electroshock therapy by Bini[1] in 1938, there has been widespread use of this method of therapy in all types of psychiatric disorders. It would no doubt be difficult to discover a single mental institution in any part of the world which does not have a "shock machine," and there are probably few psychiatrists in private practice in this country who do not include such an instrument in their office equipment. In many circles it has apparently become the most essential adjunct of psychiatric practice. Certainly among the laity it has become so associated with the most advanced therapies in psychiatry that anyone professing to practice psychiatry without the use of such an instrument would be considered incompetent and woefully out of date. Without question, the general public has the utmost faith in its efficacy and considers it for all practical purposes a cure-all of all mental diseases. While most of this faith can be attributed to the glowing accounts in the lay publications, yet certainly some of it is the result of the indiscriminate use of this therapy by the profession itself. So widespread has been its use that it is becoming difficult to find a mental patient whose disease has been of any but the briefest duration who has not already at some time in the past experienced one or more courses of shock therapy. The literature is replete with multiple reports of series extending into the hundreds and thousands of "shock therapy cases" and often with conflicting conclusions. In the beginning, as is usual in all new types of therapies, the reports were invariably enthusiastic, but as time has passed these have become less favorable and even in some instances have been unfavorable. Ten years have now elapsed since its introduction and perhaps a more critical estimation is now possible. An attempt at such an evaluation will be made in this presentation.

During at least the first five years of electroshock therapy, the machine most commonly used was undoubtedly of the type originally used by Bini.[1] This consisted of a device for the utilization of ordinary electric light circuits operating on an alternating frequency of 50 to 60 cycles, with an attached voltmeter for regulating voltage, and an automatic time clock on relays for interrupting the flow of current in fixed multiples of tenths of seconds, usually varying from one tenth to five tenths of a second. In addition, some instruments had an attached low voltage trial circuit for measuring the resistance of ohms of 1 milliampere of current passing through the the patient's head. Some instruments had even more elaborate refinements, including a device which would set the exact milliamperage flow permitted through the patient's head, and often had various signal lights, all of which, while probably impressive, are scarcely necessary; since the resistance is so variable in individual patients and even differs in the same patient from day to day during shock treatment, and no definite relation exists between the resistance and the amount of current necessary to produce a convulsion, its measurement seems useless. It is therefore believed that the simplest instrument which regulates only the voltage and the time is adequate for all practical purposes.

As regards the voltage and the duration of current flow, many different technics are in present use. Some workers set the time interval at an arbitrary figure of two tenths or three tenths of a second, and increase the voltage until a convulsion occurs, while others do exactly the opposite, by keeping the voltage fixed and increasing the time interval. All sorts of rationalizations are given for each method, but none seems particularly impressive, since in the final analysis the object is to obtain a convulsion preferably by the use of the lowest voltage and briefest current flow. It appears that this criterion is obtained only by the empiric method of trial and error, first starting with a known average nonconvulsive setting and increasing until a convulsion is reached. In view of the known fact that the individual threshold usually increases with each convulsion, this factor is further noted to be particularly true. It might be mentioned that the threshold is lower in the male than in the female, and in the young than in the middle-aged and older patients. It is also higher in dehydrated and acutely excited patients, and in those given such an anticonvulsive drug as dilantin, and can be decreased by the use of pitressin. In addition, it has been noted that the threshold is higher on cold dry days.

Read before the Florida Neurology and Psychiatry Society, Second Annual Meeting, St. Augustine, April 11, 1948.

Regardless of the exact technic used, a suprathreshold amount of current will result in a convulsion. This is hardly distinguishable from a typical spontaneous epileptic seizure. It presents a sudden flexion of the whole body followed by a tonic phase of about ten seconds' duration, succeeded by a slowly beginning clonic phase which at first shows rapid and short movements, later developing slower movements of wider range, which gradually fade out after about thirty seconds, the whole accompanied by apnea. This sequence has been labeled as the immediate type. Two other common types are recognized, namely, the petit mal seizure which is manifested by a momentary flush, succeeded usually by a sudden flexing of the body, followed by immobility and apnea and unconsciousness, though occasionally exhibiting confused excited behavior, and the third type called the delayed convulsion. This latter exhibits the initial flexion followed by a period of relaxation of varying length, which is succeeded by the typical tonic and clonic phases, which, in this type, may be a unilateral response. The final coma and postconvulsive confusional states are shorter in electrically-induced than in spontaneous seizures.

Exactly what occurs to the brain when the current is applied is still a matter of much discussion. The primary difficulty results from a lack of postmortem material. There have been relatively few mortalities occurring during the course of shock therapy, and in nearly all of these cases the changes noted in the brain could be explained on the basis of such pathologic changes present as those incident to age, to syphilis of the central nervous system, to hypertension or to brain tumor. Among the most frequent findings have been diffuse petechial hemorrhages, degeneration of nerve cells, perivascular fibrosis and necrosis and demyelination of axis cylinders. It is debatable whether these changes are the direct resultants of the current on the parenchyma or are indirectly due to the vascular spasm and hemorrhage caused by the current, or whether the convulsion itself produces most of them. Gralnick[2] was of the opinion that at the present time there is not enough evidence to indicate that there occurs consistent specific brain pathology that is directly attributable to shock therapy. And what has been found has not manifested itself in clinical neurologic symptomatology. Liberson[3] quoted Rubinstein[3] as stating repeated electroshock produces first increase of slow rhythm and then depression of all electrical activity. Kalinowsky and Hoch[1] described the immediate appearance of slow waves over the entire cortex with the reappearance of the alpha waves when consciousness recurs; normalcy appears within five to thirty minutes after the first few seizures, but after more seizures the normal pattern persists, usually for from one to five weeks in patients receiving six or less convulsions, one to three months after seven to twelve convulsions and two to six months or even longer when more treatments are given. He concluded, however, that these findings are reversible and cannot be used for prognostic determinations nor to indicate the necessary duration of treatment. Pacella, Piotrowski and Lewis[5] concluded Rorschach testing on electroshock-treated schizophrenics fails to show evidence of deterioration in either the improved or unimproved cases, but gives definite evidence that no basic personality change takes place in schizophrenics as a result of electric convulsive treatment. One effect of a successful electric convulsive treatment observed by these authors was the improved capacity of the patient to be on his guard in disclosing his personality deficiencies.

Various studies and often conflicting findings have been reported as to what types of cases have the best prognostic expectations. It seems to be the consensus that the affective disorders have a higher rate of remissions, with the best results in reactive depressions. It is difficult to assess the value of this therapy in psychoneurosis, since some reports are very favorable and others are extremely discouraging. Gold and Chiarello[6] considered prognosis from the standpoint of existing symptomatology rather than definite diagnosis and concluded that the best prognosis can be expected in those cases presenting perplexity and confusion, muteness, fear of immediate personal threat or danger, as well as depression, and suicidal intent, with an exogenic precipitating factor, a duration of less than a year, sudden onset, a previous satisfactory adjustment to life, and in the age groups of 11 to 20 years and 51 to 60 years. It might be mentioned here that these same factors were also found in those cases showing the highest rate of spontaneous remission in untreated patients long before shock therapy appeared.

Until recently there appeared to be wide disagreement as to the optimum number of electric convulsive treatments to administer. Some held the view that in general patients with the affective disorders benefited with fewer than were necessary in the schizophrenics; others thought

that the best criterion was the degree of improvement evidenced during the courses of the treatments, while Kalinowsky and Hoch[4] believed that at least in schizophrenics good results could scarcely be expected with fewer than thirty or even forty convulsions. More recently, Savitsky and Karliner[7] reported that excellent results were obtained by them following the administration of a maximum of five electric shock treatments in each case and they cited a series of 34 such cases in which remissions had continued for periods up to twenty-eight months. In reviewing the literature, one notes that there seems to be a decided tendency towards the use of fewer electric shock treatments in each case than was formerly the practice.

A tendency to critical analyses of the value of electric shock therapy has recently appeared in the literature. Thus Hinko and Lipschutz[8] expressed the belief that the growing popularity of electroshock in the treatment of schizophrenia is based on its relative simplicity rather than on any actually established therapeutic superiority to other methods, though it proved to be superior to insulin or metrazol in the treatment of the affective disorders. They also concluded that relapses following shock therapy are of as frequent occurrence as in the untreated cases. They favored shock therapy, however, because it decreases the initial hospital stay by as much as two thirds of its duration in the untreated cases. Salzman[9] was even more critical and concluded that the evidence tends to indicate that shock therapy increases the frequency of readmission and evidently produces deterioration and personality changes which may explain this increased readmission rate.

Electric shock treatments were instituted at the Florida State Hospital just prior to the onset of the last war. Due to the depletion of the staff, this therapy was not fully utilized until after the cessation of the war and was employed chiefly during the war years in the most disturbed type of patient, usually in acutely disturbed manics. Since then it has been more extensively used, and treatments were all given with the standard type of instrument, being supplemented during the past year by the use of the brief stimulus apparatus. This report is concerned only with treatments by the standard type of instrument. By this method, there have been treated 959 patients, receiving a total of 20,215 electric shocks, or an average of 21.07 shocks per patient. Of this group, 341 patients were considered much improved constituting 35.6 per cent of the total treated. Of the manics treated, 52.1 per cent were classified as much improved. Of the schizophrenics treated, 37.3 per cent were classified as much improved. No inference can be satisfactorily drawn from these results, since they are in agreement with those reported by some workers and much lower than those mentioned by others, and even somewhat higher than have been reported in a few instances.

SUMMARY

As might have been gathered so far from this presentation, the subject of shock therapy is still in the polemic stage. A constant perusal of the literature from month to month often results in much bewilderment, since invariably some reports are highly flattering while others are decidedly pessimistic.

At the beginning of work on this paper, it had been hoped that definite and satisfying conclusions could be arrived at concerning the present status of shock therapy, but continuing investigation has proved disappointing due to the persisting controversial state of the subject. Certainly the results at the Florida State Hospital have not succeeded in developing any interesting discoveries nor served to settle any of the multiple conflicting reports. A series of 959 cases with improvement in 35.6 per cent is reported.

About the only conclusion that can justifiably be made is that electric shock does have a definite role in the therapy of mental diseases. Any conclusions as to the exact technic, prognosis and durability of remission are still certain to find enthusiastic and even vehement proponents and opponents.

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The Journal of The Florida Medical Association

Owned and published by Florida Medical Association, Inc.
P. O. Box 1018 (Fla. Theater Bldg.)
Jacksonville 1, Florida

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MEDICAL DISTRICT MEETINGS
OCTOBER 18-22, 1948

Dr. Herman Watson, Chairman of the Council, the eight Councilors and the secretaries of the cooperating county medical societies have completed the programs and arrangements for entertainment. The fall meetings present an excellent opportunity for members to meet and enjoy the carefully selected scientific papers which have been arranged for the programs.

The officers of the Association will bring pertinent information concerning activities on a statewide scope that should be of particular interest to every physician. This is an opportunity to get a bird's eye view of some of the present day questions that are facing practitioners. One of the outstanding advantages of the medical district meetings is the informality which stimulates questions and answers.

Printed programs will be mailed to all members of the Association. Each member is urged to attend as many of these medical district meetings as possible. The meetings will open at 2:30 p.m. on the dates specified below.

Monday, October 18, 1948

Live Oak

Suwannee County Country Club
(4 miles east of Live Oak, Route 90)

Address of Welcome, C. LeRoy Adams, Jr., President, Madison-Suwannee County Medical Society

"Saddle Block Spinal Analgesia for Obstetrics," Thomas H. Bates, Lake City

Address (by invitation), "Conservative Management of Eclampsia," Stephen L. Watson, Jr., Lakeland

Tuesday, October 19, 1948

Daytona Beach

Ocean Dunes Club

Address of Welcome, Charles E. Tribble, President, Volusia County Medical Society

"The Toxemias of Pregnancy," E. Frank McCall, Jacksonville

Address (by invitation), "Fractures of Neck of Femur," Herschel G. Cole, Tampa

Wednesday, October 20, 1948

Bradenton-Sarasota

Sarasota Bay Country Club
(6 miles south of Bradenton)

Address of Welcome, Millard P. Quillian, President, Manatee County Medical Society, and John M. Butcher, President, Sarasota County Medical Society

"Type of Anesthesia in Hernia with Special Reference to the Aged," Joseph L. Selden, Jr., Fort Myers

"State Blood Bank Program," David R. Murphey, Jr., Tampa

Friday, October 22, 1948

West Palm Beach

Flotilla Club
(4850 Poinsettia Avenue)

Address of Welcome, Victor Clarholm, President, Palm Beach County Medical Society

"Practical Considerations Concerning Management of Nephritis," Scottie J. Wilson, Fort Lauderdale

Address (by invitation), "Total Laryngectomy," J. Brown Farrior, Tampa

After the scientific assemblies, addresses will be given at each of the four medical district meetings by the officers of the Association:

Joseph S. Stewart, President
Walter C. Payne, President-elect
Robert B. McIver, Secretary-Treasurer
Webster Merritt, Assistant Editor of The Journal
Duncan T. McEwan, Chairman, Board of Governors

At 5:45 p.m., refreshments will be served by the host societies. Dinner will follow at 6:30 p.m.

TWISTED FIGURES

While the Brookings Report[1] should by no means be construed in a manner to lull a single physician into complacency or a sense of security regarding his profession, physicians should find satisfaction in the way in which this able study reiterates with particular clarity certain facts medical leaders have emphasized again and again.

That figures do not lie is a common adage. But they can be made to be misleading and can even be manipulated to give a false impression. The Report thoroughly analyzes the selective service statistics showing high rejection rates of young men disqualified for military service because of defect and disease and points out many inaccuracies and confusions. Draft rejections on the basis of lack of height, loss of a finger, or other minor impairment could hardly offer proof of national health deficiency. Too, as the need for manpower increased, standards were lowered, permitting acceptance of many men originally rejected.

The conclusion reached—that these statistics "are unreliable as a measure of the health of the Nation and cannot be used to show the extent of the medical needs of the country as a whole"—has been the contention of the medical profession all along. So convincing are the reasons cited that one finds concurrence at this point even in the critical review of the Report published at the instigation of such rank proponents of compulsory health insurance as Senators James E. Murray and Claude Pepper. In this critique it is acknowledged that the selective service statistics "have sometimes been overused in an endeavor to demonstrate a 'shocking' state of health among young American men."

In addition to the use of these statistics to convey "an exaggerated impression of the lack of medical care," there is a wholly different aspect of juggling figures. From the lay viewpoint, what price dollars? In evaluating the expenditure of his dollars, where in the scale of values does the individual citizen place medical care? Is it his prerogative to make this decision, or must his government force upon him by law its decision in the matter?

The research incident to the Brookings Report indicates that the large majority of American families have the resources to pay for adequate medical care if they elect to give it a high priority among the several objects of expenditure. It is noted that curtailment of luxury items in food, clothing and shelter and reduction in expenditures for alcoholic liquors, automobile ownership and operation, tobacco and recreation would permit a material increase in medical care.

Too often, the disinclination of the average family to give medical care priority over nonessentials is confused with inability to pay. "The issue," the Report concludes, "is not whether they can afford medical care but whether they should be compelled by law to pool their risks and to give payment for medical care a top priority. The major alternative for people with ability to pay is to leave them free to determine for themselves what medical care they desire and whether they will pool their risks through voluntary arrangements."

1. Bachman, George W., and Meriam, Lewis: The Issue of Compulsory Health Insurance, Washington, D. C., The Brookings Institution, 1948. This is the third in a series of editorials commenting on the Brookings Report.

WORLD MEDICAL ASSOCIATION

Doubtless many members of the Florida Medical Association have kept abreast of the rapid strides made by the World Medical Association since its organization in Paris in September 1947. With commendable vigor it has attacked the many international problems affecting medicine at the present time, and it is hoped that the movement will aid in the establishment of the genuine peace of which the world stands so much in need.

Dr. Louis H. Bauer of New York is the general secretary of this promising organization of global scope. Through his office surveys are now in progress concerning the status of the physician in different countries of the world, the standards of medical education, the qualifications and rating of specialists, the extent of

recognition of cultist practice, and the advertising of medical products. A bulletin is to be issued periodically reporting the results of these studies and affording information regarding "the manner in which physicians throughout the world are joining to sustain the ethics and the ideals that have animated the medical profession for thousands of years."[1]

Every physician who participates in civic and medical affairs has an interest in the studies undertaken by this worthy organization and no doubt adds his endorsement to that of the House of Delegates of the American Medical Association, other medical organizations and great medical industries. It would be of interest to know how many members of the Association here in Florida have added to their blessing tangible evidence of their support.

Opportunity is given individual physicians to become Founder Sustaining Members of the World Medical Association. The annual membership dues are $10, and individual members will receive the bulletin of the World Medical Association and certificates of membership in the United States Committee, established to aid its work. Many physicians are subscribing for five years in advance to help place the organization promptly on an established basis. To share in this worthy cause by affiliating with the United States Committee of the World Medical Association, physicians may address the World Medical Association at its permanent offices in New York City at 2 East 103rd Street.

1. The World Medical Association, J. A. M. A. 137:1133-1134 (July 24) 1948.

HOW ACTIVE IS YOUR COUNTY MEDICAL SOCIETY?

When the American Medical Association came into being in May 1847, "a nobler spectacle was never presented by the medical profession of any age or county," according to Dr. N. S. Davis, able medical historian and moving spirit in its inception. The association immediately entered upon the work of "cultivating medical science, fostering our own medical literature and elevating the medical character." The influence of the new national organization was reflected at once in the reanimation and increased activity of old associations and societies, in the formation of new ones, in more free and liberal intercourse among medical men, and in a more lively and universal sense of the high aims, interests and responsibilities of the profession.

At the first annual meeting the next year President Nathaniel Chapman paid eloquent tribute to the delegates present in these words:

> This assemblage presents a spectacle of moral grandeur delightful to contemplate. Few of the kind have I ever witnessed more imposing in its aspect, and certainly none inspired by purer motives, or having views of a wider range of beneficence . . .
>
> The pilgrimage you have performed in coming hither, at so many sacrifices of comfort and convenience, evinces the ardour of your zeal, and the loyalty of your devotion . . .

Now, a century later, a distinguished trustee of that association deplores the overorganization of medicine, with the specialty societies in many instances reducing interest in the activities of the county medical society, lowering attendance at its meetings and diminishing its influence in the community. Dr. Louis H. Bauer, president of the Medical Society of the State of New York and executive director of the World Medical Association, makes a timely plea for more activity within county medical societies.

That his plea should be heeded can hardly be questioned in view of the times. With the present deep involvement of medicine in the solution of community problems and the guidance of social forces, surely there has never been a greater need for the alert and powerful county medical society.

There rests upon your county medical society not alone the responsibility for its influence as a local group. Through it, in addition, must channel the effectiveness of the Florida Medical Association and the American Medical Association.

And where, in turn, does your particular county medical society look but to you—the individual physician—for its power, its usefulness in the community—its very life? With Dr. Bauer we ask: Are you doing all you can to strengthen the arm and to forward the work of your county medical society?

PERSONAL WEAPONS

Many a man prides himself on being quick on the trigger, and no man likes to think that he is defenseless. It is doubtful, however, whether even the doctor, who knows his anatomy, realizes the potentialities of the personal weapons nature has provided. Greater knowledge might help him not only to defend himself if need be but also to explain better some of the wounds he is called

upon to treat. The law enforcement officer, carefully trained in the use of these weapons, offers valuable tips.

Personal weapons are those parts of the body which can be used for self defense and for counterattack. These weapons are exceedingly important in defensive tactics, and no one who uses them with intelligence and any degree of skill need consider himself unarmed.

There are special blows to fit the body's numerous structural weaknesses which are decidedly vulnerable to attack. Take, for example, the hand as a weapon. To make the edge-of-hand and edge-of-fist blows most effective, one uses a chopping motion across the body with the palm down or strikes downward with the palm facing in. Reserve these blows for the bridge of the nose, lips, throat, back of the neck, spine or kidneys. Hold the fingers rigid for the finger-jab to the throat or eye and for the extended-knuckles blow to the temple, but deliver the heel-of-hand blow to the chin upward at close range with the hand slightly cupped. Also particularly effective on the chin is the fist blow, but the fist and edge-of-fist blows have many uses. The cupped hand blow is for the ears.

The elbow, fully flexed, is a handy weapon, used most effectively for blows delivered toward the rear or outward across the body. In the forearm blow, from shoulder height with elbow fully flexed, the arm swings sharply forward and toward the inside.

The foot proves useful for kicking forward with the toe, to the side with the edge, ball and heel, and stamping down with the heel. At times, short snappy kicks, using the forward foot, are extremely effective on shin or knee. Then there is the knee lift to the face and groin, with the knee fully flexed.

Nor is the head to be overlooked as a reasonably formidable weapon, which one should not hesitate to use on occasion. Even the amateur will find it more expedient to butt it in self defense against an adversary than against the proverbial stone wall.

And remember—if the opponent is the stronger, use his strength to his disadvantage. If he pushes, pull. Outsmart him. The brain, after all, is the indispensable weapon, the one that makes personal weapons man's first line of defense.

PROFESSIONAL SERVICES IN HOSPITALS

One of the current pressing problems of the medical profession and the hospitals is the relation between hospitals and staff physicians in certain branches of medicine—anesthesiologists, pathologists, roentgenologists and physical therapists in particular. The matter is important. Failure to attack the problem intelligently now will only prolong and doubtless aggravate the present detrimental effect upon the medical profession, the hospitals and the innocent bystanders, the patients.

Inevitably, blunders have been made. But it is perhaps true that they are not so much to be condemned as is failure to correct them. To quote comment offered editorially elsewhere, "The mistake is common when businessmen, occupied chiefly with balance sheets, have jurisdiction over institutions that are staffed by professional men jealous of the ethics and etiquette of their profession. Even the physician turned director is too often found, at least in the eyes of his former colleagues, worshipping the golden calf instead of heeding the commandments written in stone."[1]

It would seem that the state medical societies might well assume leadership in the solution of this vexing problem. The Massachusetts Medical Society has pioneered the way in a constructive report of a special committee appointed "to define hospital services and medical services and to establish the proper relation between physicians and hospitals."[1] It is suggested that this approach is worthy of emulation and that "discussion of this report by similar groups in the various states might be highly useful in evolving a workable and fair practice by which all parties at interest could benefit."[2]

The report defines as medical hospital services those "other than administrative rendered by a registered physician directly to or in behalf of an individual patient for the obtainment and interpretation of data, including consultation and advice, for the diagnosis, treatment, and prevention of disease." Specifically, these services are defined as embracing "the general and special practice of medicine, surgery, and obstetrics, and the practice of the related specialties including anesthesiology, physical medicine, radiology, pathology, and clinical pathology . . . ."

Recommended in the report is the basic principle "that each department (so far as possible)

be self-supporting and that neither the hospital nor the physician rendering the service should exploit the patient or each other. The basis of financial arrangement, however, might be salary, commission, fees or any other method that would best meet the local situation."

Certain aspects of the whole matter are open to debate, and the questions arising are by no means easily answered. Nevertheless, for the medical profession to ignore the problem is not merely to evade a grave responsibility but also to invite attempts at solution from less qualified agencies. A great deal of further study and experimentation on this moot subject is necessary.

1. New England Journal of Medicine, April 29, 1948, p. 640.
2. New York State Journal of Medicine, July 1, 1948, pp. 1457-1458.

SOUTHERN MEDICAL ASSOCIATION MEETS IN MIAMI—OCTOBER 25-28

Florida is honored to have the Southern Medical Association return this month to its famous playground and convention city for the annual meeting for the second time in two years. Miami is a royal host. This time Dinner Key, the city's new convention center, provides the setting. And an ideal setting it is. Through a century this tiny key jutting into beautiful Biscayne Bay has courted fame, first locally as a picnic ground and later as an internationally famous air base and terminal. Since the recent war the City of Miami has purchased the Dinner Key hangars and converted two of them into a huge auditorium for housing conventions and expositions, and the marina, the old Pan American terminal building, is now a restaurant.

Monday, October 25, will be "Miami Day" with a clinical program entirely by the local profession. Beginning on Tuesday and continuing through Thursday, October 26-28, the twenty-one sections will each have one half-day session, as the streamlined type of program adopted during the war will be continued this year. An excellent scientific program and extensive exhibits all presented in a convenient and compact setting offer a wide variety of material of current scientific interest to every physician.

With sailboats, yachts and fishing craft dotting the limpid water of the Bay for background and "Fun After We Work" the keynote for all the recreational diversion the area offers, the Forty-Second Annual Meeting of the Southern Medical Association promises to be even more popular than the highly successful 1946 meeting.

The Florida Medical Association bids the physicians of the South and their guests a hearty welcome.



at
Miami, Florida

AN INSPIRING MEDICAL MEETING—the Annual Meeting of the Southern Medical Association in Miami, Florida, October 25-28. In the general clinical sessions by Miami physicians and surgeons, the twenty-one sections and the scientific and technical exhibits, every phase of medicine and surgery will be covered—**the last word in modern, practical, scientific medicine and surgery.** Addresses and papers by distinguished clinicians not only from the South, but from many parts of the United States.

REGARDLESS of what any physician may be interested in, regardless of how general or how limited his interest, there will be at Miami a scientific program and recreational facilities to challenge his every interest and make it worth-while for him to attend.

ALL MEMBERS of state and county medical societies in the South are cordially invited to attend. And all members of state and county medical societies in the South should be and can be members of the Southern Medical Association. The annual dues of $5.00 include the Southern Medical Journal, a journal valuable to physicians of the South, one that each should have on his reading table.

SOUTHERN MEDICAL ASSOCIATION
Empire Building
BIRMINGHAM 3, ALABAMA

NEW EDITION OF FISHBEIN'S "MEDICAL WRITING"

On July 2, 1948 there came from the Blakiston press the second edition of MEDICAL WRITING, THE TECHNIC AND THE ART by Morris Fishbein, M.D., editor of The Journal of the American Medical Association. In its preparation the author was aided by his assistant, Jewel F. Whelan. This unique volume should be an indispensable part of every medical author's library, as noted under Books Received in this issue of The Journal.

The book represents the gradual evolution of theory and practice associated with the conduct of the editorial department of the American Medical Association for some thirty-five years and supercedes in extensively revised form the various previous editions of the ART AND PRACTICE OF MEDICAL WRITING. It will be of service to physicians and writers in all scientific fields preparing articles ranging from the briefest report to a full treatise. It offers help in formulating style, in abbreviation, spelling and capitalization rules and in proofreading and indexing. From its pages one may glean the essential knowledge needed to assure proper treatment of a scientific or a medical subject and find expert guidance in the display of individuality and literary talent.

Its eighteen chapters are entitled: An Acceptable Paper; Style; Subject and Material; Construction of the Manuscript; Words and Phrases; Spelling; Capitalization; Abbreviations; Numbers; Pharmaceutic Products and Prescriptions; Biographic Material; Preparation of the Manuscript; Illustrations; Tables and Charts; Revision of the Manuscript; Proofreading; Indexing; Abbreviation of Names of Periodicals.

NEW HIGH IN HOSPITAL BIRTHS

Of more than three and a quarter million live births recorded for 1946, 82.4 per cent occurred in hospitals, 12.2 per cent were attended by physicians outside hospitals and 5.4 per cent were attended by midwives or other nonphysicians. The figures for Florida were 73.4 per cent, 11.2 per cent and 15.4 per cent, respectively. These statistics are in sharp contrast to those for 1935, the first year such data were compiled. Then only 36.9 per cent of the confinements occurred in hospitals, 50.6 per cent of the registered births were attended outside hospitals by physicians and 12.5 per cent were attended by midwives and others.

Reflected in this new high record set in 1946 are relatively large differences in the figures for white and nonwhite groups, and lesser ones for urban and rural areas. Nearly all (98.4 per cent) of the white births were attended by physicians and about seven in eight (87.1 per cent) occurred in hospitals; for nonwhite births less than two out of three (65.2 per cent) were attended by a physician and less than half (45.2 per cent) occurred in hospitals. For urban residents, 97.9 per cent of the registered live births were attended by physicians and 92.5 per cent occurred in hospitals; for rural residents, the corresponding proportions were 89.6 per cent and 67.1 per cent.

Compiled by the National Office of Vital Statistics, these data were summarized in a release late in August by the Federal Security Administrator. They indicate that in 10 other states besides Florida 10 per cent or more of the births were attended by nonphysicians. In 14 states 25 per cent or more of the births occurred outside a hospital.

SOUTHEASTERN CANCER SEMINAR TAMPA, NOVEMBER 8-10

The Cancer Seminar of the Southeastern States will be held on Nov. 8, 9 and 10, 1948, at the Tampa Terrace Hotel in Tampa. The Seminar is under the direction of the Tumor Clinic of the Tampa Municipal Hospital and is sponsored by the American Cancer Society, Florida Division, and the Florida State Board of Health.

The program includes morning and afternoon sessions, with presentation in panel discussion of such subjects as carcinoma of the breast, lung, uterus, ovary and stomach, and lymphoblastoma-leukemia.

At each symposium the subject will be discussed by a surgeon or an internist, a pathologist and a roentgenologist, who will handle the various phases of diagnosis, pathology and treatment.

At the end of each panel discussion, thirty minutes will be allowed for questions submitted by the audience.

This Seminar is conducted for the doctors of the Southeastern States and is primarily intended for the benefit of physicians in the general practice of medicine. Specialists in any field of medicine are, however, urged to attend.

Requests for hotel accommodations should be sent to Mr. A. K. Dickinson, Tampa Chamber of Commerce, Tampa, Fla. State in your communication that you are attending the Cancer Seminar.

NEW BLUE SHIELD SCHEDULE OF BENEFITS

On Sept. 1, 1948, a new and revised Blue Shield Schedule of Benefits became effective. This new Fee Schedule, as it is more commonly called, is broken down in greater detail and is more comprehensive than the one which has been in use since the organization of the plan. Before deliberating on the changes that have been made, a short history of the development of the Fee Schedule from the time the plan was organized until the present might be appropriate.

When the Florida Medical Service Corporation, better known as the Blue Shield Plan, was organized in 1946, the Florida Medical Association set up a Schedule of Benefits itemizing some 200 surgical procedures and the amounts to be paid by the plan to participating physicians for such surgical procedures. It was evident at the time the original fee schedule was drawn up that it was not comprehensive and that special consideration would have to be given to procedures not listed therein. A Claims Committee made up of participating physicians was appointed by the Board of Directors of the Florida Blue Shield Plan to meet when necessary to give special consideration to unusual claims and set up fees to be paid for procedures which were not shown in the fee schedule. This practice has been in effect since 1946.

As the Blue Shield Plan grew in both number of members and number of claims, it became evident that a new and more complete fee schedule was necessary. Since the Blue Shield Plan was organized by the Florida Medical Association, the Board of Directors of the plan appealed to the Board of Governors of the Florida Medical Association to take the necessary steps for the rewriting of the fee schedule. The Board of Governors appointed a committee composed of specialists in the various branches of medicine to meet and review the fee schedule of the Florida Blue Shield Plan. This committee is called the Board of Review and is set up on a permanent basis to meet whenever necessary for the purpose of reviewing the fee schedule of the Florida Blue Shield Plan and recommending necessary changes to the Board of Governors of the Florida Medical Association.

Copies of fee schedules of other Blue Shield Plans were sent to the members of the Board of Review for their individual study and comparison. A meeting of the Board of Review was held in October of 1947. At this meeting, after considerable discussion and deliberation, it was agreed to use as a model the fee schedule of the Massachusetts Blue Shield Plan, which in the opinion of all members was the most comprehensive of all fee schedules in current use, the Massachusetts plan being one of the oldest and most successful of all Blue Shield Plans. After the decision of the Board of Review to use the Massachusetts fee schedule as a model, each member was given a section of the Massachusetts fee schedule to study in detail and compare with the fee schedule of the Florida plan, each member being assigned the section of the fee schedule pertaining to his specialized branch of medicine. After careful study and consideration, reports were submitted by the individual members of the Board of Review to the Board of Governors of the Florida Medical Association, setting forth their recommendations for additions to, or changes in, the fee schedule of the Florida Blue Shield Plan. When reports had been received from all members of the Board of Review, the Board of Governors advised the Blue Shield Plan that the recommendations had been accepted, and submitted the recommended changes to the Board of Directors of the plan for approval. A detailed study was then made by the Blue Shield Plan to determine whether or not the cost of the revised fee schedule as recommended by the Board of Governors could be borne by the plan at the rates then being charged the public for these

services. Upon the completion of this study the Board of Directors approved the proposed fee schedule which was put into effect on Sept. 1, 1948. All participating physicians have been mailed copies of this new Schedule of Benefits.

While the original fee schedule of the Florida Blue Shield Plan listed approximately 200 surgical procedures, the new fee schedule is broken down into 871 procedures. The maximum amount of $150 paid by the plan remains the same, but in many cases the amounts of surgical procedures have been increased. The new Schedule of Benefits also shows alongside of each procedure the code number which is used by the plan in setting up the claim. Participating physicians are urged to show the identifying code number for surgical procedures on the Doctor's Service Report when filing claim against the Blue Shield Plan. This new fee schedule will facilitate the prompt payment of claims to physicians as it will eliminate the loss of time involved in presenting to the Claims Committee surgical procedures which were not listed in the former fee schedule. As previously stated, the Board of Review is a permanent committee appointed to study and recommend necessary changes in the fee schedule of the Blue Shield Plan, and as the plan continues to grow, further changes will be made, increasing the benefits both to subscribers and participating physicians.

STATE BOARD OF HEALTH

DIRECTOR OF BUREAU OF LABORATORIES GIVEN HONOR BY ARMED FORCES

At ceremonies held in the library of the State Board of Health in Jacksonville on July 26, 1948 Dr. Albert V. Hardy, Director, Bureau of Laboratories, was presented a "Certificate of Appreciation" on behalf of the War Department and the Navy Department.

Captain F. F. Sima, U. S. N., representing the Navy, paid tribute to Dr. Hardy's leadership in research. Colonel R. G. Howie, Commanding Officer of the Florida Military District, represented the Army and made the award. The certificate was presented in recognition of Dr. Hardy's contribution to the advancement of medical science during World War II in connection with studies of the dysenteric diseases. This work was done at the National Institute of Health and in cooperation with the Office of Scientific Research and Development.

Dr. James W. Ferris recently has become health officer of the unit composed of Hardee, DeSoto and Charlotte counties with headquarters at Arcadia.

Dr. Albert O. Ryan has been appointed assistant health officer to Dr. Edwin G. Riley in the Polk County Health Department at Bartow.

Dr. Joseph H. Batsche has accepted the position of assistant director of the Rapid Treatment Center at Melbourne.

Dr. Holland M. Carter is serving as health officer of the unit composed of Madison and Taylor counties with headquarters at Madison.

Dr. Daniel H. Rowe, former health officer of the unit composed of DeSoto, Charlotte and Hardee counties, has accepted the position of house officer at the Boston City Hospital in Massachusetts.

Dr. Burton F. Austin has assumed his duties as health officer of the Palm Beach County Health Department with headquarters at West Palm Beach. He formerly was state health officer in Alabama. Dr. Charles G. Chaplin, former health officer of the Jefferson County Health Department, has been appointed Dr. Austin's assistant.

Dr. G. L. Beaumont is the newly-appointed health officer of the unit composed of Highlands, Glades and Hendry counties with headquarters at Sebring.

Dr. Raymond J. Dalton, health officer of the Lake County Health Department for many years, has resigned his position, effective Aug. 1, 1948.

STATE NEWS ITEMS

Dr. Charles C. Hillman of Miami was recently honored when the British Consul conferred upon him the insignia of Honorary Commander of the Military Division of the Order of the British Empire for outstanding services during the war. Dr. Hillman is superintendent of Jackson Memorial Hospital.

Dr. Raymond L. Evans of Miami has become associated with Dr. John W. Snyder in the practice of surgery. Their offices are located at 402 Huntington Building.

Dr. Luther W. Holloway of Jacksonville and Dr. Warren W. Quillian of Coral Gables were members of the faculty of the Southern Pediatric Seminar which was held July 5-17 in Saluda, N. C. Dr. Holloway lectured on "Tetanus and Tetany" and "Congenital Obstruction in the Gastrointestinal Tract." Dr. Quillian treated the subjects "Anemia" and "Child Health Services."

Nine members of the Association attended the seminar. They are Drs. Burns A. Dobbins, Jr., Ft. Lauderdale; James B. Parramore, Key West; Charlotte E. Champion and Leland H. Dame, Orlando; William G. Meriwether, Plant City; Reddin Britt and Robert D. Harris, Jr., St. Augustine; Frank L. Quillman and Harry Z. Silsby, Sanford.

Dr. Robert H. Mickler of Tallahassee has opened his offices for the practice of medicine at 516 North Adams Street.

Dr. Irwin S. Leinbach has returned to St. Petersburg after a three months' tour of ten countries in Europe. Dr. Leinbach, who visited orthopedic surgeons and saw surgery in seven of the countries, was impressed with the fact "that their abilities, instruments and techniques were equally as good as ours in America, with very few exceptions." He reported that in the region of the city of Quimper, Brittany, there were approximately 3,500 persons with congenital hip lesions, either dysplasias, subluxations, or complete luxations. The area is composed of approximately 70,000 persons.

MEDICAL DISTRICT MEETINGS

The chairman of the Council, Dr. Herman Watson, has announced that the dates of the four Medical District meetings have been officially set by the Council as follows:

Live Oak, Monday, Oct. 18, 1948

Daytona Beach, Tuesday, Oct. 19, 1948

Bradenton - Sarasota, Wednesday, Oct. 20, 1948

West Palm Beach, Friday, Oct. 22, 1948

See complete program on page 231.

Dr. Lucien E. Myers of Winter Park was the guest speaker at a meeting of the local Rotary Club in the early part of August.

Dr. Eugene G. Peek, Jr., of Ocala, after serving two years in the U. S. Army Medical Corps, has returned to be associated with his father in the practice of medicine.

Dr. Starling P. Alderson of Miami was the guest speaker at the Miami Beach Rotary Club luncheon on August 10.

Miami physicians attending the recent meetings of the American Gastro-Enterological Association and the American Society for Clinical Investigation held in Atlantic City included Benjamin G. Oren, Jack O. W. Rash and Paul N. Unger.

DEATHS

DEATHS — MEMBERS

Dr. Clifford J. Gay, Jacksonville	Aug. 5, 1948
Dr. Frank L. Hall, Sarasota	July 14, 1948
Dr. James W. Smith, Miami	July 14, 1948

DEATHS — OTHER DOCTORS

Dr. Robert C. Strode, West Branch, Mich.	April 5, 1948

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Editor's Note:

The purpose of the Academy is to promote a program of public relations under the supervision of the Florida Medical Association. At present all officers and members of the Academy are also members of the Florida Medical Association.

WEEKLY HEALTH COLUMN

Additional requests for the weekly health column, "Health Topics," continue to come into the office of the Academy of Public Medicine. This health information is now being received regularly by fifty-nine weekly and semi-weekly newspapers in the state. The column is restricted to these smaller newspapers and is released only to those who have indicated, after being contacted, that they desire the service. Watch for "Health Topics" and express your appreciation to the newspaper editor.

MEDICAL SUPPLEMENT

The August Journal reported a special medical public relations project sponsored by the Escambia County Medical Society. On June 27 an eighteen page medical supplement appeared as a part of the regular Sunday edition of the Pensacola News-Journal. The doctors of West Florida had presented the story of the medical profession to the public. Copies of the supplement may be obtained from the Academy office by any county medical society desiring to study this type of project.

RADIO PROGRAMS

Electrically transcribed medical programs, produced by the American Medical Association, are being carried on a number of stations throughout the state. At this writing they are on the air once each week from WTMC, Ocala; WFLA, Tampa; WLAK, Lakeland; WLBF, Leesburg; WEUS, Eustis; WDBO, Orlando, and three times weekly from WVCG, Miami. Many radio stations change programs during the summertime and revise their schedules again to start in early fall. WPDQ, Jacksonville, will again broadcast these medical programs starting some time in September. A. M. A. platters are available from the Academy.

EMERGENCY MEDICAL SERVICE

The Dade County Medical Association has established a Military Service Committee for the immediate study of a proposed program designed to protect the interests of both the public and the medical profession in the event of another national emergency. This is in line with similar actions taken by the American Medical Association and the Florida Medical Association, at the suggestion of the A. M. A.'s Council on National Emergency Medical Service. Apparently among the first of the county societies in the nation to take such action, the Dade Association's proposal rated commentary in the News Letter of the A. M. A.'s Council on Medical Service, with the heading "Leading the Way."

PUBLIC RELATIONS CONFERENCE

For the first time doctors serving on public relations committees, and laymen specialists in charge of medical public relations, will convene in St. Louis on November 27 in their own national conference.

DR. IRONS SPEAKS OUT

In his speech of acceptance on elevation to the office of president-elect of the American Medical Association, Dr. Ernest E. Irons issued a warning against complacency by physicians in regard to the potentiality of federal compulsory health insurance. Dr. Irons believes the danger is as great as ever. He urges county and state medical societies to stimulate their members to greater activity in letting the public know the inherent danger to individual freedom which lies in a proposal of this type.

MEDICAL LICENSES GRANTED

Dr. Frank D. Gray, Secretary of the State Board of Medical Examiners, has reported that of the 169 applicants who took the examination of the Board, held June 29-30, in Jacksonville, 161 passed and have been issued licenses to practice medicine in Florida. The names and addresses of the 161 successful applicants follow:

Abrashkin, Mortimer Dick, Coral Gables (Maryland 1932)
All, Frank Ewbank, Jacksonville (Emory 1942)
Alsup, Fred Werthly, Tallahassee (Howard 1947)
Altman, George Lawrence, Chicago (Illinois 1945)
Ames, Richard Haight, Winston-Salem, N. C. (Duke 1940)
Anderson, Donald Hood, Panama City (George Washington 1947)
Andrews, John Robert, Chagrin Falls, Ohio (Western Reserve 1932)
Arenson, Nathan, New Orleans, La. (N. Y. Med. 1937)
Arnold, Harry Dudley, Jr., Holly Hill (Chicago 1947)
Bailey, William Arthur, Baltimore, Md. (Wayne 1943)
Baker, Roy Maynard, Jacksonville (Emory 1948)
Barger, John Alexander, Jr., Melbourne (St. Louis 1932)
Beaumont, Godfrey Luke, Sebring (Pennsylvania 1932)
Beebe, Milton Omar, Jr., St. Petersburg (Rush 1940)
Blumstein, Charles Lewis, Columbus, Ga. (Louisiana State 1938)
Brody, Benjamin, Brooklyn, N. Y. (N. Y. Homeopathic 1916)
Buchanan, Arthur Paul, Jr., Tampa (McGill 1942)
Butt, Cecil Gascoyne, Orlando (Emory 1947)
Carmona, Manuel Gumersindo, Rochester, Minn. (Jefferson 1941)
Castro, Alejandro Francisco, Washington, D. C. (George Washington 1942)
Cato, Robert Eugene, Americus, Ga. (Emory 1947)
Chandler, James Ryan, Jr., Daytona Beach (Duke 1947)
Chaplin, Charles Garnet, Monticello (Michigan 1946)
Clark, George Beach, Bradenton (Tennessee 1944)
Corbitt, Jack, Hartford, Ala. (Tulane 1944)
Cordova, Arturo Ortiz, Miami (Pennsylvania 1947)
Cunningham, Charles Barnard, St. Petersburg (Michigan 1934)
Daughtrey, John Estes, Atlanta, Ga. (Emory 1942)
Daversa, Joseph James, Brooklyn, N. Y. (Long Island 1934)
Davis, Carl Henry, Wilmington, Del. (Rush 1909)
Davis, Henry Clinton, Wilmington, Del. (Pennsylvania 1946)
Dean, William Jesse, St. Petersburg (Emory 1948)
Deeb, Nasseef Augustus, Tallahassee (Loyola 1942)
DeLisa, Dominick Anthony, Richmond, Ind. (Albany 1943)
Domeier, Luverne Henry, St. Petersburg (Loyola 1940)
Douglass, Lawton Frank, Citra (Virginia 1946)
Dunlap, Edward Amberson, New York (Western Reserve 1935)
Dunlap, Ernest Brindley, Jr., Jacksonville (Duke 1939)
Dunsford, Ensor Rubidge, Jr., Jacksonville (Vanderbilt 1948)
DuRant, Julian Muldrow, Madison (South Carolina 1945)
Eckart, Emile Peter, Jr., East Tallahassee, Ala. (Louisiana State 1943)
Exum, William Allen, Snow Hill, N. C. (Duke 1941)
Field, Richard David, Lafayette, La. (Tulane 1942)
Flipse, Robert Charles, Jamaica, N. Y. (N. Y. Med. 1948)
Folsom, Thomas Gillespie, Huntington, W. Va. (Cincinnati 1932)
Gauzza, Valentine Paul, St. Augustine (Baylor 1921)
Gilbert, Joseph West, Jr., Jacksonville (Emory 1948)
Goldstein, Leopold, Philadelphia (Pennsylvania 1922)
Gottsch, John Erwin, Shenandoah, Iowa (Iowa 1947)
Grayson, Robert, Miami Beach (Columbia 1943)
Greenberger, Isidore Milton, New York (Royal Col. Med. Edinburgh 1937)
Greenfield, Maurice Murray, Miami (Ohio State 1943)
Groom, Dale Lemuel, Rochester, Minn. (Virginia 1943)
Hamerick, George, Jr., Burgettstown, Pa. (Pittsburgh 1937)
Hammond, Daniel Oscar, Miami (Maryland 1945)
Harris, Jack Kenneth, Jacksonville (Emory 1948)
Harrison, Ira Barnett, Jacksonville (Emory 1948)
Harsh, John Foster, Birmingham (Columbia 1943)
Harvey, Bennett Brown, Mount Dora (Indiana 1939)
Hauss, John Frederick, Miami Beach (Ohio State 1937)
Havener, William Henry, Cleveland, Ohio (Western Reserve 1948)
Head, Robert Grady, Marianna (Tennessee 1940)
Henry, Jimmy Farthing, Melbourne (Washington University 1944)
Hernandez, Moises Sergio, Miami Beach (Baylor 1940)
Hertner, John Ernest, Avon, Ohio (U. of Cincinnati 1943)
Hodges, Emory Falcon, Jr., St. Petersburg (Virginia 1947)
Holmes, James Walter, Miami (Tulane 1946)
Hunter, John Willis, Jr., Birmingham, Ala. (Washington 1938)
Hutchison, William Charles, McKeesport, Pa. (Pittsburgh 1927)
Hyman, Barnett Morton, Beaumont, Tex. (Tennessee 1936)
Jacobs, John Brown, Brooklyn, N. Y. (Western Reserve 1941)
Jenkins, Paul Hamilton, Ocala (Nebraska 1932)
Jensen, Marshall N., Blair, Neb. (Nebraska 1933)
Johnson, Thomas DeVann, Hawthorn (Emory 1948)
Kamer, Lawrence, Bronx, N. Y. (Middlesex 1945)
Kaminski, Bernard Adam, Miami Springs (Northwestern 1947)
Kantor, Samuel, Chicago, Ill. (Illinois 1938)
Kaplan, Samuel Elihu, Greenville, Ga. (Kansas City U. 1938)
Keigh, Walter Perry, Jacksonville (Arkansas 1944)
Kercheval, John Mavine, Clinton, Ind. (Indiana 1925)
Keys, Harry James, Jacksonville Beach (Ohio State 1941)
Kline, Lewis LeRoy, Detroit, Mich. (Coll. Med. Evangelists 1940)
Knauer, William Jerome, Jr., Jacksonville (George Washington U. 1948)
Lasley, Charles Haden, Atlanta, Ga. (Harvard 1947)
Lewis, John Ransom, Jr., Louisville, Ga. (Emory 1941)
Liddy, Eugene Daniel, Jr., Lawrence, Kan. (Kansas 1935)
MacLean, Richard Howard, Tampa (Northwestern 1948)
McDermid, John Turner, Vidalia, Ga. (Georgia 1948)
McKay, Ernest Gary, Tampa (Temple 1948)
McNeely, Henry Hyde, Toccoa, Ga. (Georgia 1946)
Magnon, West Bitzer, Decatur, Ga. (Emory 1948)
Maltzer, Joseph Herbert, Miami (Wayne 1945)
Manheimer, Leon Henry, Boston, Mass. (Harvard 1940)
Margoshes, Stanley, Miami (Bowman Gray, Wake Forest 1945)
Mason, Lester Millard, Cincinnati, Ohio (Med. Col. Virginia 1941)
Meaney, Richard Vincent, Punta Gorda (Cornell 1943)
Merrill, Joseph Howes, Jr., Palatka (Georgia 1948)
Moore, Leland O. W., Pittsburgh, Pa. (Cooper, now Leland Stanford, 1912)
Moorehead, Matthew Talmadge, Philadelphia, Pa. (Western Reserve 1923)
Morey, Horace Freeman, Lakeland (Syracuse 1933)
Neill, Robert Gleve, Durham, N. C. (Duke 1941)
Nelson, Raymond Nicholas, Bushnell (Marquette 1913)
Newbern, Walter Relfe, Palm Beach (Duke 1937)
Norley, Theodore, Philadelphia, Pa. (Hahnemann, Philadelphia 1943)
Owrey, Robert Howard, Tampa (Pittsburgh 1944)

Parker, Harold Eugene, Arcadia (Marquette 1940)
Peck, William King, New York (Columbia 1941)
Price, Raymond Miller, Oak Ridge, Tenn. (Tennessee 1926)
Proctor, William Houser, Chamblee, Ga. (Emory 1940)
Raborn, Robert E., Trenton (Tulane 1948)
Rahilly, George T. F., Nashville, Tenn. (Columbia 1941)
Raynolds, Arthur Hidden, St. Petersburg (Columbia 1926)
Reid, Charles Laurence, Jacksonville (Tulane 1947)
Rights, Clyde Siewers, Tampa (Wake Forest 1947)
Ring, Harold Henry, Belle Glade (Iowa 1926)
Robertson, George Will, III, Miami Beach (Pennsylvania 1940)
Rolfes, Harry Franklin, Lake City (Maryland 1944)
Rolls, Karl Reid, Sarasota (Coll. Med. Evangelists 1947)
Rose, Eugene Clifford, Daytona Beach (Meharry 1948)
Ross, Otho Bescent, Jr., Charlotte, N. C. (Duke 1943)
Rowe, David Lawrence, New York (Middlesex 1945)
Royer, Don John, West Palm Beach (Ohio State 1916)
Satriale, Oreste John, New York (Middlesex 1945)
Sausmer, William Abraham, Hicksville, N. Y. (Middlesex 1945)
Schochet, Sydney Sigsfried, Monroe, La. (Tulane 1914)
Schwartz, George Robert, St. Petersburg (Marquette 1932)
Shapiro, Allen David, Miami Beach (Long Island 1942)
Shashy, Samuel Abraham Moses, Ocala (Emory 1948)
Sheehan, Frank T., Opa Locka (Ohio State 1940)
Silver, Max Isadore, Douglas, Ga. (Emory 1944)
Simpson, James William, Orlando (Temple 1948)
Sims, John Norris, Comer, Ga. (Georgia 1947)
Skinner, Louis C., Jr., Coral Gables (Johns Hopkins 1940)
Smith, Elvira Corrales, Tampa (Louisiana State 1940)
Smith, James Reginald, Washington, N. C. (Meharry 1948)
Snyder, Grayson Cypher, Everett, Pa. (Pennsylvania 1947)
Speropoulos, John A., Miami (Natl. Univ. of Athens, Greece 1934)
Spicola, Louis Angel, Tampa (N. Y. Homeopathic 1935)
Steele, William Theakle, Lake City (Georgia 1944)
Steinman, William, Miami (Illinois 1941)
Stem, James Marion, Sarasota (Tennessee 1944)
Taylor, Isaiah Ewen, Huntington, W. Va. (Med. Col. Virginia 1936)
Toporoff, Jacob, West Palm Beach (N. Y. U. and Bellevue 1916)
Tromly, Robert Goodyear, Oak Ridge, Tenn. (Tennessee 1944)
Turner, Henry Haywood, II, Atlanta, Ga. (Emory 1943)
Unger, Harold Milton, Miami Beach (Columbia 1948)
Van Fleit, William Edmund, St. Petersburg (Indiana 1945)
Verdon, Franklyn Edward, New Smyrna Beach (Middlesex 1939)
Walker, Harry Burton, Jr., Vineland, N. J. (Temple 1948)
Walker, John Franklin, Ponte Vedra Beach (Emory 1948)
West, Joseph Ready, West Palm Beach (Vanderbilt 1944)
West, Joseph Warren, Owego, N. Y. (Duke 1944)
Wetzel, Dick Davis, Salt Lake City, Utah (Utah 1946)
White, Donald Palmer, Jr., Durham, N. C. (Duke 1943)
Williamson, Joseph Patterson, Ware Soals, S. C. (South Carolina 1928)
Wilson, Frances Chappell, Tampa (Washington 1943)
Wisch, Louis Jerome, DeLand (Illinois 1922)
Wright, John Edward, Coral Gables (Columbia 1943)
Yesner, Bernard, Jamaica, N. Y. (Arkansas 1940)
York, Dale Ellis, Bloomington, Ind. (Indiana 1940)
Young, Robert William, Daytona Beach (Johns Hopkins 1944)

COMPONENT SOCIETY NOTES

BAY

Members of the Bay County Medical Society were addressed by Dr. Luther C. Fisher, Jr., of Pensacola at their August meeting. Dr. Fisher spoke on hip fractures and treatment at the county health center. He illustrated his paper with roentgenograms and reported successful treatment of a hip fracture in a patient over 90 years of age.

Dr. Franklin H. Reeder, director of the county health unit, outlined requirements for patients who are receiving free insulin treatment.

Members present were Drs. Daniel M. Adams, Jr., Charles H. Daffin, James E. Kerr, Amsie H. Lisenby, James M. Nixon, Martle F. Parker, Franklin H. Reeder, William C. Roberts and Russell T. Stewart.

DADE

Dr. Chas. E. Thompson of the Veterans Administration Hospital, Memphis, Tenn., spoke before members of the Dade County Medical Association on August 3. His paper was entitled "The Internal Medical Approach to the Problem of Spinal Cord Injury."

DESOTO-HARDEE-HIGHLANDS-CHARLOTTE-GLADES

At the July meeting of the DeSoto-Hardee-Highlands-Charlotte-Glades County Medical Society, Dr. Joseph R. Campbell of Tampa spoke on "Special Hazards in the Use of Barbiturates with Particular Reference to Porphyria."

Members attending the meeting included Drs. Roland W. Banks, Henry P. Bevis, Isaac W. Chandler, Hubert W. Coleman, Merle C. Kayton, Charles H. Kirkpatrick, Ruth M. Miller, Wesley S. Pyatt, Zaven M. Seron, James G. Smith, Jr., Stanley K. Wallace and Howard V. Weems.

MANATEE

On August 12 the members of the Manatee County Medical Society entertained Mr. Bert W. Hendrickson at a dinner. Mr. Hendrickson successfully undertook a campaign to raise $150,000 for a new hospital and the Society members expressed their appreciation with a gift. At the close of the campaign, he had raised $192,000.

PUTNAM

Dr. Lawrence G. Hebel, who recently opened his practice in Palatka, has been made a member of the Putnam County Medical Society. His offices are located at 119 North Fourth Street.



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1. Kasper, J. A. and Jeffrey, I. A.: A Simplified Benedict Test for Glycosuria, Amer. J. Clin. Pathology, *14*:117-21 (Nov.) 1944.

2. Haid, W. H.: The Use of Screening Tests in the Clinical Laboratory, J. Amer. Med. Tech., *8*:606-14 (Sept.) 1947.

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CLIFFORD JACKSON GAY

Dr. Clifford J. Gay of Jacksonville died at his home on Aug. 5, 1948 following a brief illness. He was 43 years of age.

Dr. Gay was a native of Valdosta, Ga. He received his medical training at the University of Georgia School of Medicine in Augusta, from which he was graduated in 1936. Following his internship at Jackson Memorial Hospital in Miami, he practiced medicine in Monticello, Avon Park and Sarasota before opening offices in Jacksonville five years ago. During World War II, Dr. Gay served as a captain in the United States Army Medical Corps.

He was a member of the Duval County Medical Society, the Florida Medical Association and the American Medical Association.

Survivors include his widow, Mrs. Ann Frishmeth Gay, Jacksonville; three daughters, Mrs. G. K. Jones, Raleigh, N. C., and the Misses Virginia Mae and Patricia Ann Gay, Jacksonville; a son, Clifford J. Gay II, Jacksonville; three brothers, Dr. H. L. Gay, Jacksonville dentist, Newton J. Gay, Orlando, and L. F. Gay, Miami; and three sisters, Mrs. Ruby Lee King, Sanford, Mrs. Mildred Keeley, Miami, and Mrs. Glen Dora Barkholter of California.

BEN DURHAM SPEARS

Dr. Ben D. Spears of Wauchula died at his home on April 25, 1948 following a long illness. He was 56 years of age.

Dr. Spears was born in Midland City, Ala., on Dec. 13, 1891. He was graduated from the Georgia College of Eclectic Medicine and Surgery in Atlanta in 1914 and was licensed to practice the same year.

He moved to Hardee County, Fla., in 1915 and practiced in Ona and Zolfo Springs for several years. While in Zolfo Springs, he served as a member of the city council and was instrumental in initiating municipal improvements, in develop-

ing the Aqua Vitae Mineral Springs and in obtaining a new school building.

In 1926 Dr. Spears moved to Wauchula, where he practiced continuously until ill health forced him to retire a few years ago. Locally, he was a member of the Wauchula Masonic Lodge and the Shrine, and was a charter member of the Wauchula Lion's Club. He was a member of the Wauchula Methodist Church.

Professionally, Dr. Spears was a member of the DeSoto-Hardee-Highlands-Charlotte-Glades County Medical Society and the Florida Medical Association, and was a fellow of the American Medical Association.

Surviving him are a daughter, Miss Marianne Spears, and a son, Doyle Carlton Spears, both of Wauchula; a sister, Mrs. Callie McCormick, of Florala, Ala.; two brothers, B. W. Spears of Ocala, and Frank B. Spears of Midland City, Ala.

LAWRENCE LORRAINE STEPP

Dr. Lawrence L. Stepp of Fort Lauderdale died at his home on May 30, 1948 at the age of 56.

Dr. Stepp was born in Tarentum, Pa., in 1891. Following his graduation from Grove City College and the University of Pittsburgh, he entered the University of Pennsylvania School of Medicine in Philadelphia, from which he was graduated in 1917.

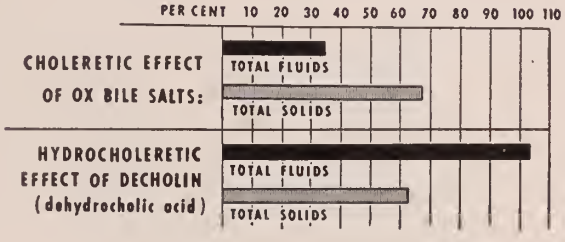
During World War I Dr. Stepp served in the United States Army Medical Corps. He came to Fort Lauderdale in 1938 from Pittsburgh, where he had been a practicing surgeon.

At the time of his death he was president of the Broward General Hospital staff, a member of the Broward County Medical Society, an honorary member of the Florida Medical Association and a fellow of the American Medical Association. He also was a member of the Nu Sigma Nu medical fraternity.

Locally, he was a member of the American Legion, the Central Improvement Association, of which he was one of the originators and the first president, the Kiwanis Club and the Yacht Club. Dr. Stepp was a member of the First Presbyterian Church in Fort Lauderdale.

He is survived by his widow, Mrs. Roma Burki Stepp.

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Ivy, A. C., et al: Am. J. Dig. Dis. 7:333 (Aug.) 1940.

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NOTES ON CONVENTION OF WOMAN'S AUXILIARY TO AMERICAN MEDICAL ASSOCIATION

In a partial report of the annual convention of the Woman's Auxiliary to the American Medical Association held in Chicago in June, Mrs. Lee E. Parmley, president of the Woman's Auxiliary to the Florida Medical Association, commented upon the tribute of Dr. Edward L. Bortz, past president of the A. M. A. Dr. Bortz stated that "in the field of human relationship the Woman's Auxiliary is our most valuable asset."

Mrs. Parmley reported that, including an increase of 7,000 women, the national auxiliary now is composed of 42,262 members. She urges that the Florida Auxiliary be the first to win the "Hygeia" plaque which has been presented to the national group. Each auxiliary has been encouraged to obtain and study the report from the Brookings Institution on compulsory health insurance.

Among the revisions of the Constitution and By-Laws of the Auxiliary to the American Medical Association was that to increase the annual dues from twenty-five cents to one dollar per member. In a letter to auxiliary presidents, Mrs. A. A Herold, treasurer of the A. M. A. auxiliary, explains that the assessment at the present time does not include subscriptions to any publications published by the national auxiliary.

BOOKS RECEIVED

MEDICAL WRITING, THE TECHNIC AND THE ART. By Morris Fishbein, M.D. Ed. 2. Price, $4.00. Pp. 292. Philadelphia: The Blakiston Company, 1948.

In this new edition of a most helpful style book for medical and scientific writers valuable and important suggestions have been well integrated and new suggestions have been incorporated. In particularly attractive garb with thirty-six illustrations, this volume is timely and should take its rightful place on the shelves of every physician's library, as pointed out in a commentary in this number of The Journal.

PROGRESS IN NEUROLOGY AND PSYCHIATRY, AN ANNUAL REVIEW, VOLUME III. Edited by E. A. Spiegel, M.D. Pp. 661. New York: Grune & Stratton, 1948.

Some two thousand eight hundred papers covering the fields of the basic sciences, neurology, neurosurgery and psychiatry have been reviewed in this volume. Sixty-nine contributors of note have made possible a considerable increase over the material reviewed in previous years.

FAILURES IN PSYCHIATRIC TREATMENT. Edited by Paul H. Hoch, M.D. Price, $4.50. Pp. 241. New York: Grune & Stratton, 1948.

The proceedings of the Thirty-Seventh Annual Meeting of the American Psychopathological Association, held in New York City in June 1947, comprise this volume and represent the first attempt to present a general review of therapeutic failures with different psychiatric methods of treatment. The book is, therefore, a unique contribution to the better understanding of the theory and praxis of psychiatric treatment.

CORRELATIVE NEUROANATOMY. By Joseph J. McDonald, M.D., Joseph G. Chusid, M.D., and Jack Lange, M.D. Ed. 4. Price, $3.00. Pp. 156. Palo Alto, Calif.: University Medical Publishers, 1948.

This comprehensive manual for the student in gross anatomy, neuroanatomy, neurodiagnosis and neurology correlates the anatomic and physiologic background with the clinical findings of neurologic disorders. It includes numerous diagrams which clearly show the distribution and functional components of the cranial, spinal and autonomic nerves, and the essentials of brain and spinal cord localization.

There are three sections, dealing respectively with peripheral nerves, neurodiagnosis, and diseases and disorders of the central nervous system. The appendix contains a complete list of neurologic signs and syndromes, a brief discussion of muscular dystrophies and atrophies and an outline of the neurologic examination.

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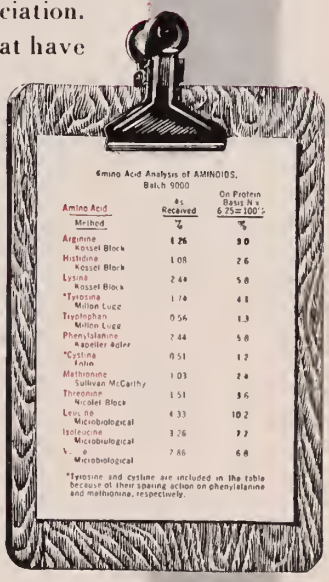
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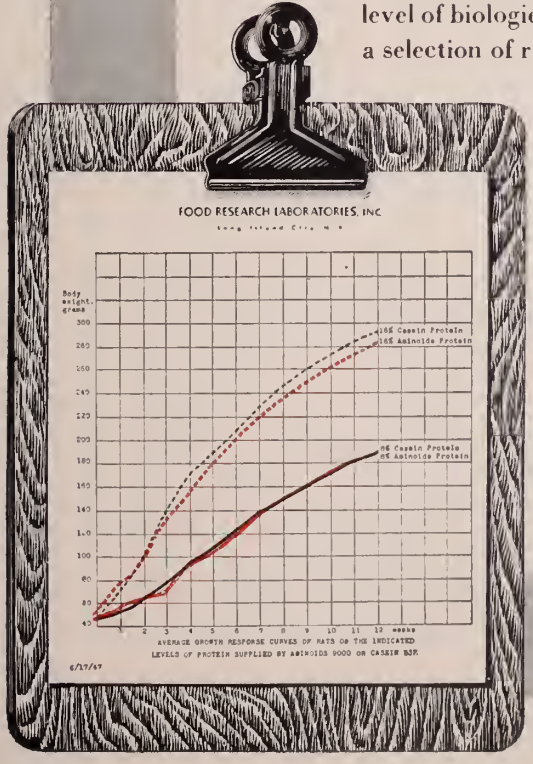
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	Leon-Gadsden-Liberty-Wakulla-Jefferson	Taylor W. Griffin, M.D. Quincy	Edward C. Love, Jr., M.D. Masonic Temple Bldg. Quincy	Quarterly 7:30 P.M.	47	46	
	Madison-Suwannee	C. LeRoy Adams, Jr., M.D. Parshley Bldg. Live Oak	Irby H. Black, M.D. 918 W. Howard St. Live Oak		7	100%	
	Taylor *Dixie-Lafayette*	Walter J. Baker, M.D. Foley	Ralph J. Greene, M.D. Perry	Last Friday 8:00 P.M.	4	100%	
	Alachua *Bradford, Gilchrist Union*	J. Maxey Dell, Jr., M.D. 331 W. Main St., S. Gainesville	F. Emory Bell, M.D. Box 400 Gainesville	2nd Tuesday 8:00 P.M.	34	33	
	Duval *Clay*	John A. Beals, M.D. 1900 Boulevard Jacksonville	Elmer E. Leitner, M.D. 33 W. Ashley St. Jacksonville	1st Tuesday 8:15 P.M.	238	227	
	Marion *Levy*	Hugh H. Barfield, M.D. 1317 S. Orange St. Ocala	Bertrand F. Drake, M.D. Professional Bldg. Ocala	3rd Wednesday 12.30 P.M.	30	25	B-3-50 Charles C. Grace, M.D. St. Augustine
	Nassau	David G. Humphreys, M.D. Fernandina	John W. McClane, M.D. Fernandina	Last Friday 8:00 P.M.	9	100%	
	Putnam	Edward W. Ford, M.D. Crescent City	James W. Davidson, M.D. 6 S. Main St. Crescent City	2nd Tuesday 6:00 P.M.	9	100%	
	St. Johns	Hardgrove S. Norris, M.D. 168 Marine St. St. Augustine	S. Raymond Cafaro, M.D. Exchange Bank Bldg. St. Augustine	3rd Tuesday 8:30 P.M.	15	100%	
C	Brevard	I. Kimbell Hicks, M. D. Melbourne	Theodore J. Kaminski, M.D. Box 576 Melbourne	2nd Tuesday	15	13	
	Lake *Sumter*	Howard G. Holland, M.D. 1112 W. Main St., Leesburg	Matthew Arnow, M.D. Eustis	1st Wednesday 7:30 P.M.	26	24	B-4-49 Rabun H. Williams, M.D. Eustis
	Orange *Osceola*	Rollin D. Thompson, M.D. Box 3513 Orlando	James G. Economon, M.D. 108 E. Central Orlando	3rd Wednesday 8:00 P.M.	135	133	
	Seminole	Harry Z. Silsby, M.D. Box 642 Sanford	Frank L. Quillman, M.D. Box 158 Sanford	2nd Tuesday 5:30 P.M.	10	100%	
	Volusia *Flagler*	Charles E. Tribble, M.D. DeLand	Robert L. Miller, M.D. 258½ S. Beach St. Daytona Beach	2nd Tuesday 7:30 P.M.	51	50	572
	Hillsborough	Douglas D. Martin, M.D. 442 W. Lafayette St. Tampa	Herschel G. Cole, M.D. 315 Wallace S. Bldg. Tampa	1st Tuesday 8:00 P.M.	142	140	
	Manatee	Millard P. Quillian, M.D. Walcaid Bldg. Bradenton	Willett E. Wentzel, M.D. Professional Bldg. Bradenton	3rd Tuesday 7:00 P.M.	18	100%	C-5-49 John M. Butcher, M.D. Sarasota
	Pasco-Hernando-Citrus	William G. Mason, M.D. Inverness	W. Wardlaw Jones, M.D. Box 247 Dade City	2nd Thursday 7:00 P.M.	14	13	
	Pinellas	M. Eldridge Black, M.D. 311 Coachman Bldg. Clearwater	Whitman C. McConnell, M.D. 313 First Federal Bldg. St. Petersburg	1st Monday 6:30 P.M.	158	156	
	Sarasota	John M. Butcher, M.D. 209 Commercial Ct. Sarasota	Talmadge S. Thompson, M.D. Box 224 Venice	2nd Tuesday 8:30 P.M.	23	100%	
D	DeSoto-Hardee-Highlands-Charlotte-Glades	Zaven M. Seron, M.D. Sebring	Howard V. Weems, M.D. 22 Oak St. Sebring	2nd Tuesday 8:00 P.M.	25	24	C-6-50 H. Quillian Jones, M.D. Ft. Myers
	Lee *Collier, Hendry*	Harvie J. Stipe, M.D. 210 Richards Bldg. Ft. Myers	H. Quillian Jones, M.D. 311 Professional Bldg. Ft. Myers	3rd Tuesday 7:30 P.M.	22	100%	
	Polk	Chester H. Murphy, M.D. Bartow	John W. Vaughn, M.D. Box 475 Lakeland	2nd Wednesday 7:00 P.M.	77	74	479
	Indian River	James C. Robertson, M.D. Vero Beach	William L. Fitts, 3rd, M.D. Vero Beach Arcade Vero Beach	2nd Tuesday 8:00 P.M.	8	100%	
	Palm Beach	Victor Clarholm, M.D. Box 672 West Palm Beach	Ralph M. Overstreet, Jr., M.D. 820 Comeau Bldg. West Palm Beach	3rd Monday 8:00 P.M.	88	85	D-7-50 Erasmus B. Hardee, M.D. Vero Beach
	St. Lucie-Okeechobee-Martin	Hugh B. Goodwin, Jr., M.D. Arcade Bldg. Ft. Pierce	Adrian M. Sample, M.D. Box 897 Ft. Pierce	3rd Thursday 8:00 P.M.	13	12	
	Broward	Milton N. Camp, M.D. 720 Sweet Bldg. Ft. Lauderdale	Alva R. Taylor, M.D. 414 Blount Bldg. Ft. Lauderdale	4th Tuesday 8:00 P.M.	62	100%	D-8-49 Russell B. Carson, M.D. Ft. Lauderdale
	Dade	Robert T. Spicer, M.D. 1110 Huntington Bldg. Miami	Benjamin G. Oren, M.D. 628 duPont Bldg. Miami	1st Tuesday 8:30 P.M.	483	462	
	Monroe	James B. Parramore, M.D. 523 Whitehead St. Key West	Herman K. Moore, M.D. 419 Eaton St. Key West	2nd Thursday 8:00 P.M.	12	100%	666

SCHEDULE OF MEETINGS

ORGANIZATION	PRESIDENT	SECRETARY	ANNUAL MEETING
rida Medical Association	Joseph S. Stewart, Miami	Robert B. McIver, Jacksonville	Belleair, Apr. 10-13, 1949
rida Medical Districts	Herman Watson, Lakeland	Council Chairman	
-Northwest	Irby H. Black, Live Oak	William P. Hixon, Pensacola	Live Oak, Oct. 18, 1948
-Northeast	Rabun H. Williams, Eustis	Charles C. Grace, St. Augustine	Daytona Beach, Oct. 19, 1948
-Southwest	John M. Butcher, Sarasota	H. Quillian Jones, Ft. Myers	Bradenton-Sarasota, Oct. 20, '48
-Southeast	Russell B. Carson, Ft. Lauderdale	Erasmus B. Hardee, Vero Beach	West Palm Beach, Oct. 22, 1948
rida Specialty Societies			
erm. and Syph., Soc. of	A. Buist Litterer, Miami	Wesley W. Wilson, Tampa	Belleair, April 10, 1949
enl. Practice of Med.	M. Crego Smith, Clearwater	Walter E. Murphree, Gainesville	Belleair, April 10, 1949
ealth Officers' Society	Roger F. Sondag, Jacksonville	Lorenzo L. Parks, Jacksonville	Belleair, April 10, 1949
ndustrial & Railway Surgeons	F. Hardy Bowen, Jacksonville	J. H. Mitchell, Jacksonville	Belleair, April 10, 1949
eurology & Psychiatry	James G. Lyerly, Jacksonville	William H. McCullagh, Jacksonville	Belleair, April 10, 1949
b. and Gynec. Society	Chas. J. Collins, Orlando	Dorothy D. Brame, Orlando	Belleair, April 10, 1949
phthal. & Otol., Soc. of	Bascom H. Palmer, Miami	W. Jerome Knauer, Jacksonville	Belleair, April 10, 1949
rthopedic Society	Charles B. Mabry, Jacksonville	Eugene L. Jewett, Orlando	Belleair, April 10, 1949
athological Society	James N. Patterson, Tampa	Gretchen V. Squires, Pensacola	Belleair, April 10, 1949
ediatric Association, State	Edgar W. Stephens, W. P. Beach	Hugh A. Carithers, Jacksonville	Belleair, April 10, 1949
roctologic Society	Dean W. Hart, St. Petersburg	Frederick E. Farrer, Miami	Belleair, April 10, 1949
adiological Society	James F. Pitman, Lake City	Floyd K. Hurt, Jacksonville	Belleair, April 9-10, 1949
rological Society	Milton M. Coplan, Miami	Russell B. Carson, Ft. Lauderdale	Belleair, April 10, 1949
rida—			
cademy, Public Medicine	Robert T. Spicer, Miami	Shaler Richardson, Jacksonville	Belleair, April 13, 1949
asic Science Exam. Board	Paul A. Vestal, Winter Park	M. W. Emmel, D.V.M., Gainesville	Gainesville, Nov. 6, 1948
ental Society, State	Horace L. Cartee, D.D.S., Miami	John I. Todd, D.D.S., Jacksonville	Hollywood, Dec. 12-15, 1948
ospital Association	Mr. James T. Pate, Jacksonville	Mr. H. A. Schroder, Jacksonville	
ospital Service Corporation	Mr. W. E. Arnold, Jacksonville	Mr. H. A. Schroder, Jacksonville	
ledical Examining Board	Homer L. Pearson, Jr., Miami	Frank D. Gray, Orlando	Jacksonville, Nov. 29-30, '48
ledical Postgraduate Course	Turner Z. Cason, Jacksonville	Chairman	
ledical Service Corporation	Leigh F. Robinson, Ft. Lauderdale	Herbert E. White, St. Augustine	
urses Association, State	Miss Elizabeth Reed, Jacksonville	Miss Helen Shearston, Miami	West Palm Beach, Oct. 17-20, '48
harmaceutical Association, State	Mr. D. M. Weaver, Miami	Mr. R. Q. Richards, Ft. Myers	
ublic Health Association	Wilson T. Sowder, Jacksonville	Mr. Fred B. Ragland, Jacksonville	Panama City, Oct. 7-9, 1948
uberculosis & Health Assn.	Judge Ernest E. Mason, Pensacola	Mr. Walton MacJordan, Orlando	May, 1949
Voman's Auxiliary	Mrs. L. E. Parmley, Winter Haven	Mrs. C. R. Morgan, Jr., Miami	Belleair, Apr. 10-13, 1949
erican Medical Association	R. L. Sensenich, South Bend, Ind.	Geo. F. Lull, Chicago	Atlantic City, June 6-10, 1949
I. A. Interim Session			St. Louis, Nov. 30-Dec. 3, '48
thern Medical Association	E. L. Henderson, Louisville, Ky.	Emmett B. Carmichael, Atlanta	Miami, Oct. 25-28, 1948
bama Medical Association	J. Paul Jones, Camden, Ala.	Douglas L. Cannon, Montgomery	Montgomery, Ala., Apr. 19-21, 1949
rgia, Medical Assn. of	Edgar Hill Greene, Atlanta	Edgar D. Shanks, Atlanta	Savannah, Ga., May 10-13, '49
. Hospital Conference	Mr. Burton M. Battle, New Orleans	Mr. R. F. Whitaker, Atlanta	Biloxi, Miss., April 27-29, '49
theastern Allergy Assn.	J. Warrick Thomas, Richmond, Va.	Kath. B. MacInnis, Columbia, S. C.	
theastern, Am. College Phys.	Webster Merritt, Jacksonville	Florida Program Chairman	Atlanta, 1948
theastern, Am. Urological Assn.	Harold P. McDonald, Atlanta	Russell B. Carson, Ft. Lauderdale	Boca Raton, March 21-24, '49
theastern Surgical Congress	Gilbert Douglas, Birmingham, Ala.	B. T. Beasley, Atlanta	Biloxi, Miss., Jan. 24-27, '49

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*R. H. Follis, D. Jackson, M. M. Eliot, and E. A. Park: Prevalence of rickets in children between two and fourteen years of age, Am. J. Dis. Child. 66:1-11, July 1943.

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Vol. XXXV NOVEMBER, 1948 No. 5

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Spinal Muscular Atrophy
I. Irving Weintraub

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John A. Toomey

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An Editorial

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Volume XXXV NOVEMBER, 1948 No. 5

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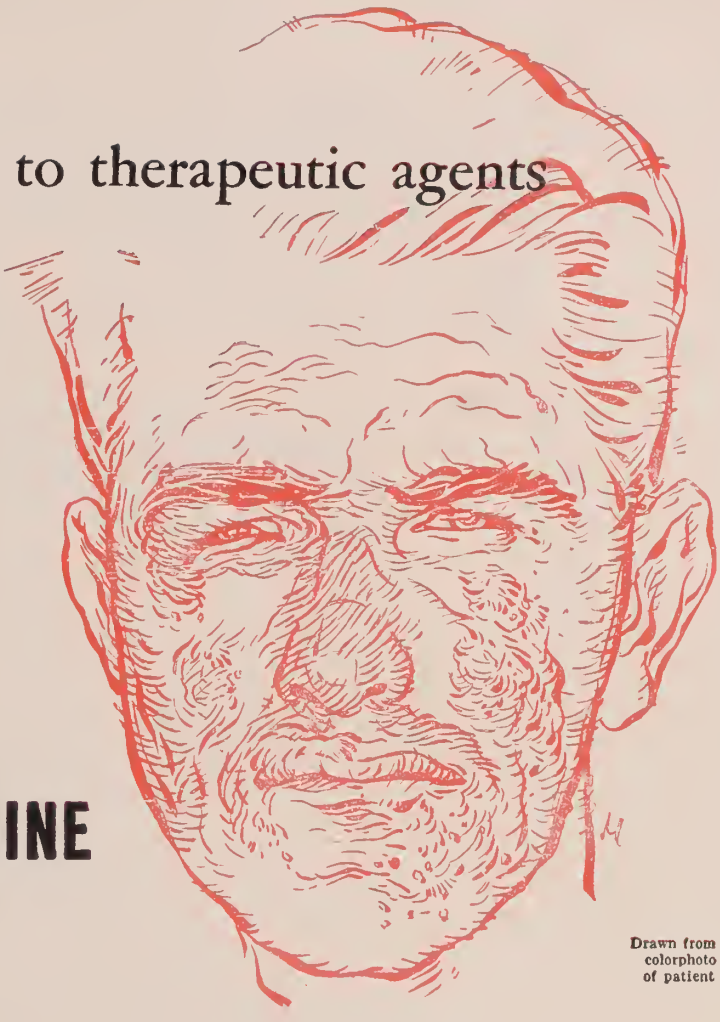
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This Journal is not responsible for the opinions and statements of its contributors.

Published monthly at Jacksonville, Florida. Price $5.00 a year; single numbers, 50 cents. Address Journal of the Florida Medical Association, P. O. Box 1018 (Fla. Theater Bldg.), Jacksonville 1, Fla. Telephone 5-0577. Accepted for mailing at special rate of postage provided for in Section 1103, Act of Congress of October 3, 1917; authorized October 16, 1918. Entered as second-class matter under Act of Congress of March 3, 1879, at the post office at Jacksonville, Florida, October 23, 1924.

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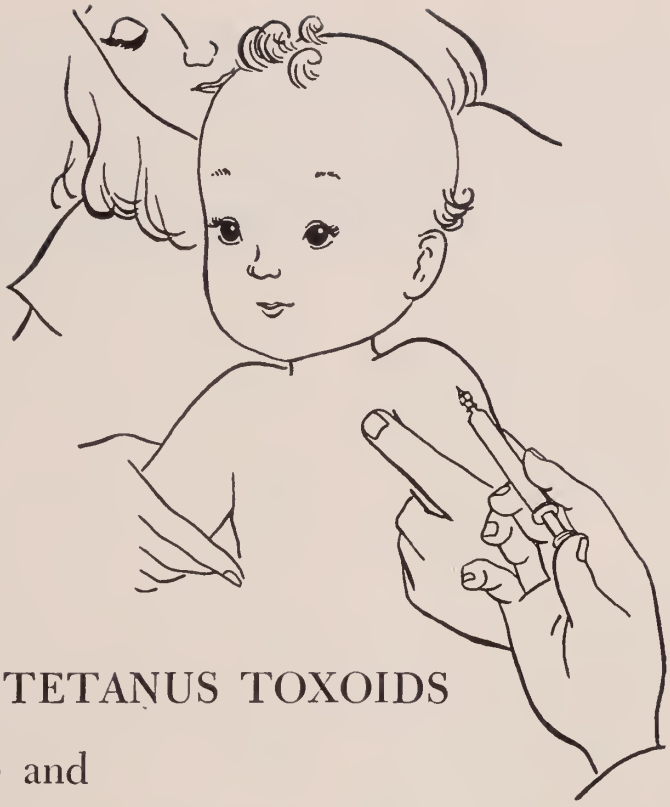
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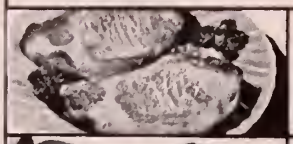
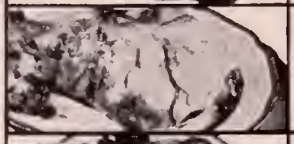
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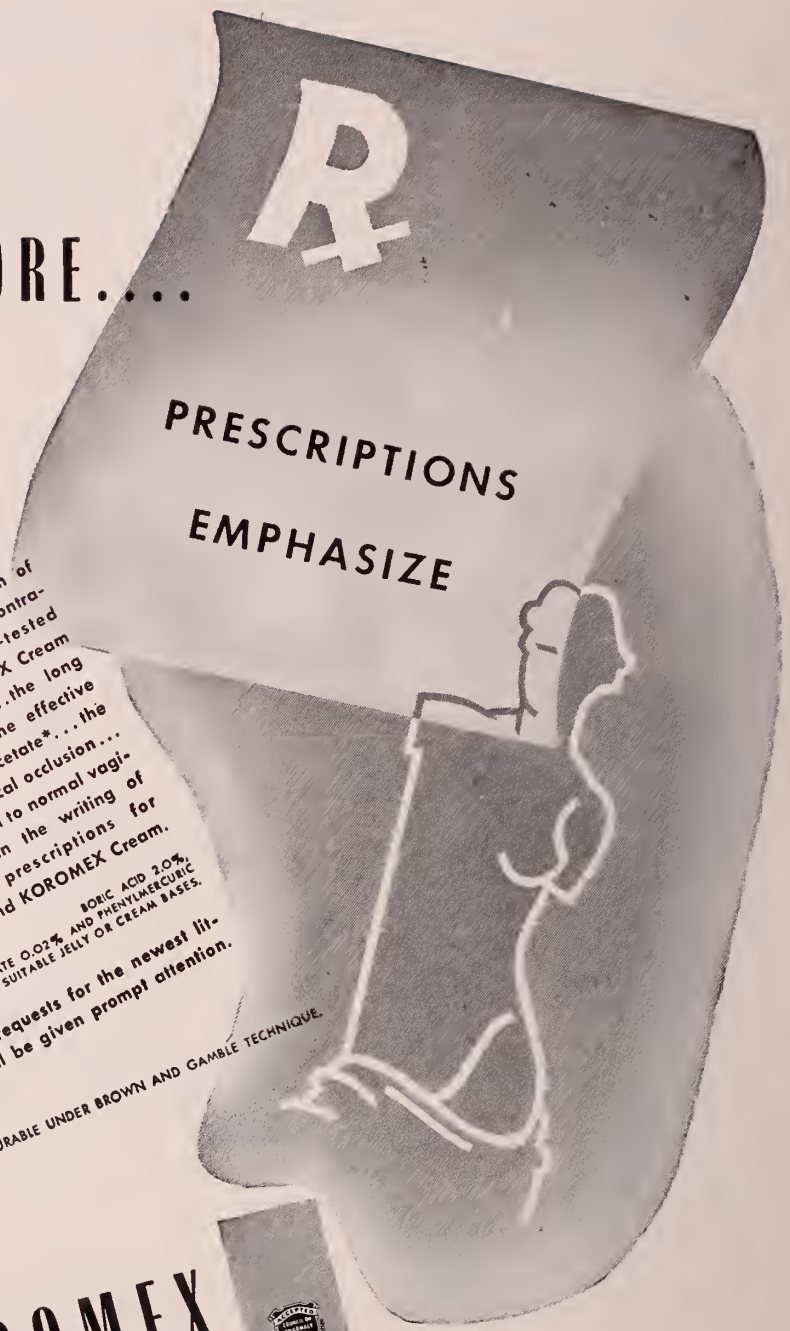
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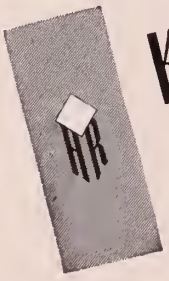


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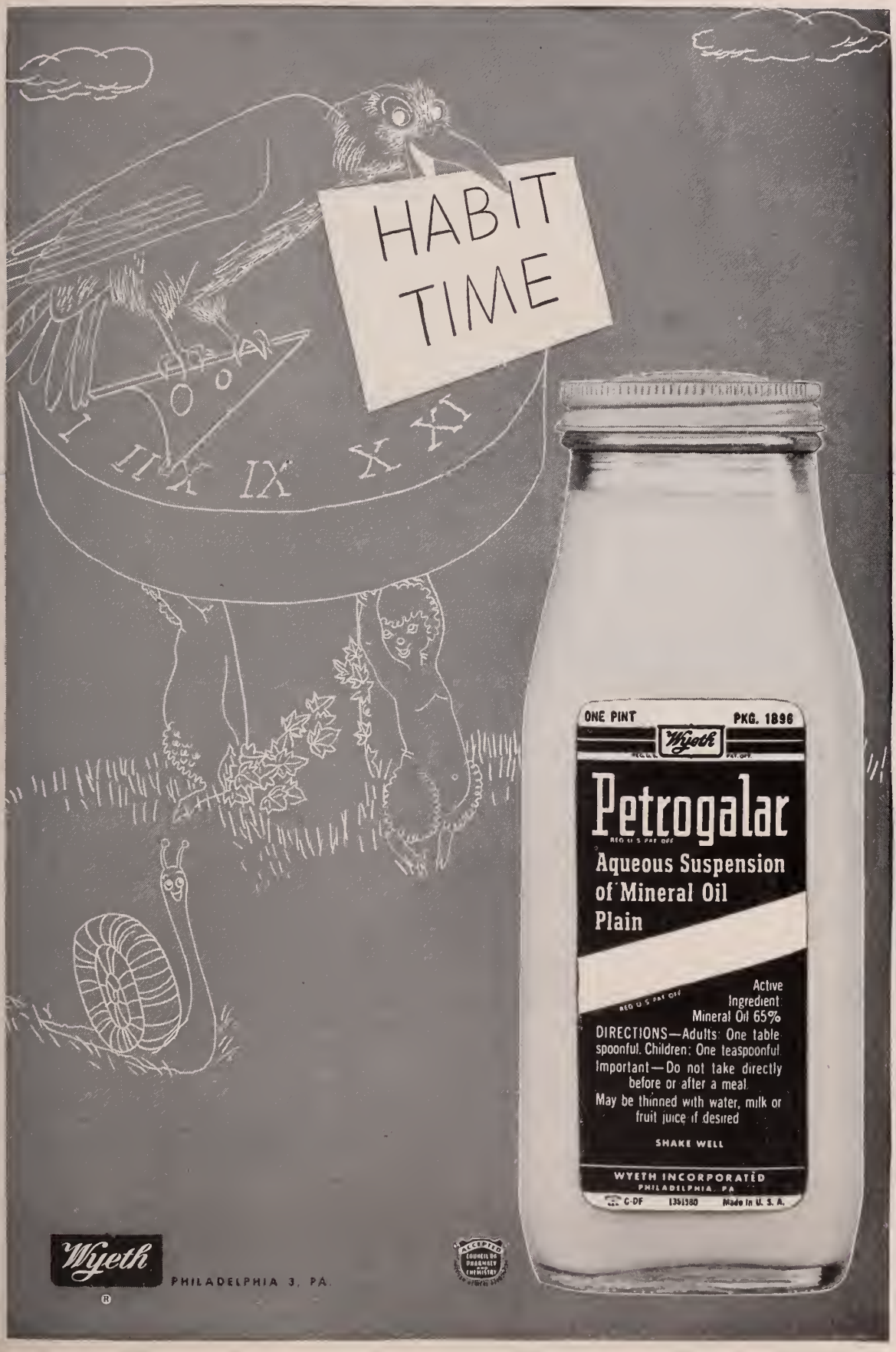
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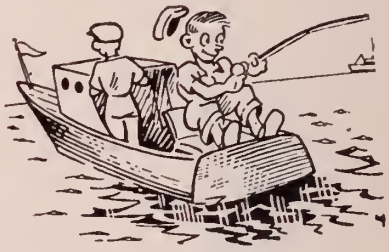
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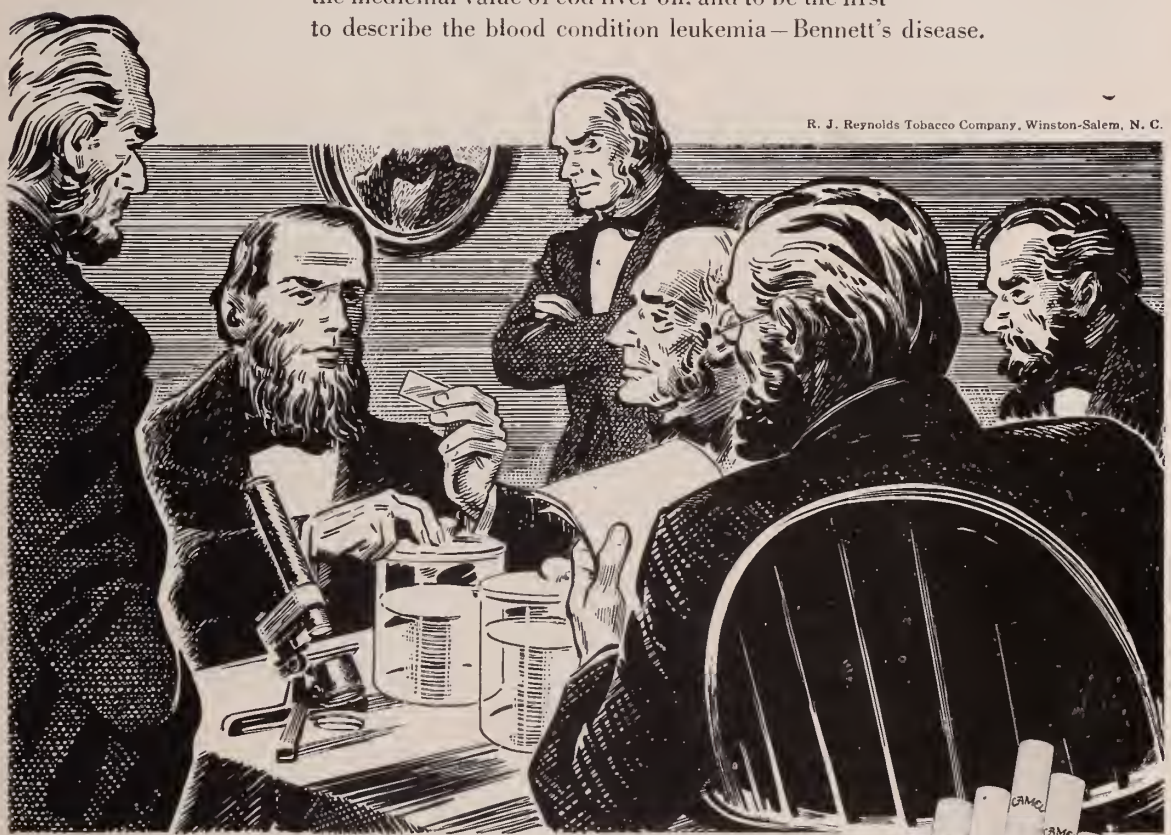
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*Downing, J. G., Hanson, M. C. and Lamb, M.: Use of 5-Nitro-2-Furaldehyde Semicarbazone in Dermatology, J. A. M. A. *133*:299, 1947. • Shipley, E. R. and Dodd, M. C.: Clinical Observations on Furacin Soluble Dressing in the Treatment of Surface Infections, Surg. Gynec. & Obst. *84*:366, 1947. • Miller, J., Rodriquez, J. and Domonkos, A.: Evaluation of Penicillin in Topical Therapy, New York State J. Med. *47*:2316, 1947.



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THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION
PUBLISHED MONTHLY
Volume XXXV Jacksonville, Florida, November, 1948 No. 5

Hemiplegia: Treatment by Stellate Ganglion Block

THOMAS C. BUTT, M.D.
AND
FRED MATHERS, M.D.
ORLANDO

No symposium on hypertension would be complete without a discussion of the cerebral vascular accidents which are such distressing complications of this malady. When a diagnosis of hypertension is made, that alone is enough to produce anxiety and fear of a "stroke" in the minds of both the patient and his relatives. We particularly wish to relate our experiences with stellate ganglion block in attacking some of the problems arising with hemiplegia.

The use of procaine block of sympathetic ganglia to allow predominance of vasodilator control has become a well established procedure in the management of acute occlusions of the peripheral vascular tree. The cerebral vessels also are under both parasympathetic and sympathetic control, but, as would be expected, the reactivity of this nervous control of cerebral blood flow is not clinically significant since the blood supply of the brain must remain remarkably constant as a protective mechanism. Furthermore, studies made on the vascular physiology of the brain and particularly the neurogenic mechanism of control by physiologists have tended to show that the vasomotor mechanisms as regards the cerebral vessels are unimportant. On the other hand, clinicians have witnessed many incidents of fleeting and quickly reversible neurologic phenomena which could only be explained by cerebral vascular spasm.

The stellate ganglion carries the sympathetic outflow fibers to the brain, upper extremity, thoracic viscera and a portion of the viscera of the upper part of the abdomen.[1] Blocking this ganglion to overcome residual spasm of cerebral vessels and to salvage anoxic and edematous tissue surrounding the zone of injury would seem to be a logical procedure. Leriche and Fontaine[2] in 1936 and Mackey and Scott[3] in 1938 reported the usefulness of stellate ganglion block in the management of apoplexy. Further elucidation by American authors has been accomplished.[1,4,5,6]

We use a modified anterior approach which in our hands has produced uniformly good results. It must be borne in mind, however, that any technic carries with it certain dangers. Since injection of procaine into the spinal canal or intravenously, pneumothorax or trauma to the cord may occur, this procedure should not be done by untrained personnel. The patient is placed in the supine position with the head turned to the opposite side from which the block is to be done. A midclavicular point is identified, and the tubercle of Chassaignac is palpated. The skin is prepared with ether, alcohol and merthiolate, and the area is draped. A small skin wheal is made with 1 per cent procaine 1 cm. above the midclavicular point and a 20 gauge spinal needle is directed towards the sixth transverse process previously identified by the tubercle of Chassaignac. When bony contact is made at a depth of 3 to 4 cm., the needle is slightly withdrawn and redirected downward and inward to make bony contact again at a 2 to 3 cm. deeper level with the transverse process of the seventh cervical vertebra. The stellate ganglion is usually situated between this transverse process and the neck of the first rib.

At this point a 10 cc. syringe filled with 1 per cent procaine is attached to the needle, and a test is made for blood, spinal fluid or air. A drop of procaine placed on the hub of the needle will be aspirated when the patient inhales, if the tip of the needle is intrapleural. Having reassured ourselves that the needle is in a safe location, the transverse process is followed inwards by "walking" the needle point towards the body of the vertebra. This is done with the syringe attached so that if the ganglion is inadvertently stimulated by the needle point so as to produce reflex spasm of the coronary arteries and anginal

Read before the Florida Medical Association, Seventy-Fourth Annual Meeting, St. Augustine, April 11-14, 1948.

pain, a few drops of procaine can be quickly injected. When the body of the vertebra is reached and a final test for air, blood and spinal fluid made, 10 to 15 cc. of 1 per cent procaine is slowly injected. The objective signs of a successful block appear within a few minutes and include Horner's syndrome of ptosis of the lid, miosis, dryness and increase in temperature of the face and upper extremity of the injected side, and increased vascularity of the conjunctiva.

We believe that a clinical classification of cerebral vascular accidents on an etiologic basis of hemorrhage, thrombosis, or embolism is essential since patients suffering from cerebral hemorrhage should not be subjected to stellate block, or at least it should not be done until a long period of observation has indicated that bleeding has ceased. Aring and Merritt[4] presented criteria for this differentiation which we have found useful.

For purposes of illustrating the results to be expected, representative cases are briefly cited.

Case 1.—Mrs. F. P., a 56 year old white woman, suffered a "stroke" in 1940 from which she made a slow recovery. When seen on Nov. 3, 1947 she walked with the typical hemiplegic gait and had no use of the right arm. Her main problem was to secure relief from the severe constant pain in the paralyzed arm. The loss of function was considered by her and her husband as the inevitable result of the cerebral vascular accident. The pain in the arm was so severe as to suggest a thalamic element. She was given a procaine block of the left stellate ganglion on two occasions, forty-eight hours apart, and much to her surprise was able to comb her hair and sew a little with the right extremity. She thought that the pain was not relieved, but her husband believed that there had been a great improvement since she slept well at night and did not complain of pain as before.

Case 2.—Mr. F. C., a 63 year old white man, suffered a cerebral thrombosis in 1942 resulting in a left-sided hemiplegia. He had made a good recovery in that he walked well with the use of a cane and could use the left arm, but fine movement of the fingers was lost. He also had begun to suffer severe pain in the left arm, for which he sought relief. He was given a right stellate block on two occasions with improvement in function and freedom from pain. When last examined two months afterwards he stated that he no longer used a cane for walking and was now able to count his money, and shuffle and play cards; he had had no pain in the arm.

Case 3.—Mr. W. T., a 65 year old white man, was seen in November 1946, three months after a cerebral thrombosis which had resulted in a right-sided hemiplegia. His injury was rather extensive in that he showed a weakness of the right side of the face, a paralysis of the right half of the tongue, fair use of the right leg so that he could walk with a cane, but a useless spastic right arm. There had developed serve constant pain in the right arm which prevented sleeping except under the influence of sedatives. The right arm was edematous; the skin was shiny and cold, and any passive motion of the fingers or wrist was extremely painful. A left stellate block was performed on Nov. 18, 1946 and again on November 21. Six days later he was seen in the office. The swelling was gone from the arm, there was ability to flex slightly and extend the fingers, and he had been able to discontinue all remedies for pain. A check six months later revealed the same findings as before, and the improvement had been maintained.

These 3 cases represent the results of treatment of residuals of hemiplegia resulting from cerebral thrombosis and cerebral hemorrhage which were of seven years, five years and three months duration respectively. Spontaneous recovery in these cases had ranged from poor to good as regards function. We used stellate block in each case in an effort to secure relief from the causalgic-like pain of which these patients complained. In 1 case the pain was so severe as to suggest a thalamic component. In each case relief from pain was gratifying. The functional return was in each case moderate, and the amount of improvement varied inversely with the degree of impairment. The patient showing the least impairment made the best recovery, and the patients with the most functional loss secured the least improvement of motor function.

Case 4.—Mr. A. K., a 62 year old white man, was admitted to the Orange Memorial Hospital twenty-six hours after a cerebral vascular accident. He was immediately placed in an oxygen tent because of respiratory difficulty. The onset had been gradual with progressive loss of use of the right arm and right leg, and finally respiratory depression. Examination revealed an apathetic but conscious man who was unable to speak or swallow, and a flaccid paralysis of the right arm and leg.

A left stellate block was done immediately. A typical Horner's syndrome developed, and the patient made an effort to speak and to move the right arm and leg. He could at this time swallow and demanded a drink of water, which he drank with relish. The improvement only lasted thirty minutes, and he had to be returned to the oxygen tent. The following morning the block was repeated, and the improvement lasted forty-five minutes. The following day he was out of the tent and appeared stronger, but no sustained improvement had occurred. The patient, however, was the most enthusiastic member of the party. Each time we would visit him, he would motion with the good hand to the site of injection indicating his desire for a block. Following each block he would demand a drink. During the next sixteen days block was carried out at frequent intervals without permanent good results. It was then decided to block the contralateral ganglion. Following this procedure the improvement was permanent, and he was able to take nourishment with ease. At no time was the return of speech satisfactory, and some dysarthria always remained. Examination one year later revealed that he was able to get about, to care for himself and to eat normally, but still had impairment of speech.

This is an example of the results of early treatment in a case of cerebral thrombosis. This patient was in a critical condition upon admission to the hospital and made a rapid recovery, regaining the ability to swallow, some return in speech and rapid use of the leg and arm. At the end of twenty-four days' hospitalization he returned home with maximum recovery. Possibly all of this improvement would have been spon-

taneous, but we believe that months would have been required for this to occur. This case also illustrates the value of bilateral stellate ganglion block in cases in which the improvement is not maintained.

Case 5.—J. W., a Negro man, was admitted to the Orange Memorial Hospital on March 12, 1947 in a semicomatose condition, and no history could be obtained. Examination revealed an elderly Negro lying quietly in bed; the right side of the face was paralyzed, the tongue deviated to the right, and the right arm and leg exhibited spastic paralysis. Swallowing was difficult, sips of water being taken with effort.

The left stellate ganglion was blocked, and there was immediate improvement in the patient's condition. He was alert, could swallow easily and speak his name. He made no effort to move the right extremities until encouraged, and then it was noticed that he could flex and extend the fingers some and move the right leg slightly. After this block was done, further history was secured, and it was learned that this patient had suffered his first vascular accident one year previously, which had resulted in his being paralyzed on the right side and unable to speak or care for himself without assistance. The recent episode occurred the morning of admission. Two other blocks were done, forty-eight hours apart, and maximum improvement seemed to be secured. Six days later he was discharged, at which time he was able to be about with aid, swallow normally, use the right arm and leg to some extent and speak well enough to make his wants understood. When seen one year later he was walking with the aid of a cane and caring for his daily needs, which he could not do before the second episode of cerebral thrombosis.

This case is an example of the results secured in a patient who had the residuals of an old cerebral injury as well as a recent second episode. His status was considered by him and by his family as being much improved over what it was before the second thrombosis.

Case 6.—Mrs. C. H. F., a 79 year old white woman, was admitted to the hospital on Jan. 11, 1947. She was known to have had diabetes and hypertension for at least ten years. The day preceding admission, she suddenly lost the ability to speak, swallow and move the right arm and leg. When seen, she was semicomatose, aphasic, and the right arm and leg were involved with flaccid paralysis. There were loud rhonchi throughout the lung fields. It was thought that she had had a cerebral hemorrhage. Her condition deteriorated during the next three days. A stellate ganglion block was done with prompt return of consciousness and ability to say a few words, and move the right arm and leg. The improvement was temporary, and she quickly lapsed into coma and died the following day.

This case is an example of temporary improvement in a seriously ill patient with cerebral hemorrhage. The progress of this patient was progressively downhill, and a fatal outcome was expected. The temporary return of consciousness and improvement suggests that there is an area of brain tissue which is anoxic and edematous surrounding the zone of injury which rapidly responds to increase in blood supply secured by cerebral vascular dilatation.

DISCUSSION

These observations verify the findings of Risteen and Volpitto[1,4] and Gilbert and de Takats.[7] Karnosh and Gardner[5] concluded that this method of treatment yields only questionable functional improvement but that it does create a definite alteration in mood so that a sense of well-being amounting to almost euphoria results. This change in emotional level from one of depression to one of elation was believed to account for the seemingly improved motor ability. It is difficult for us to accept this view, and case 4 alone is adequate proof of the functional improvement.

CONCLUSIONS

From our experience we would recommend immediate and repeated stellate blocks in cases of recent cerebral thrombosis. This method materially shortens the period of recovery and also yields maximum return of motor function. In cases of old hemiplegia from either hemorrhage or thrombosis relief of pain can be secured and some functional improvement. The greater the recovery that has ensued spontaneously the better the results from the block. If no sustained result is secured, a block of the contralateral ganglion should be done. The explanation for this seemingly anatomic paradox is not clear. Use of this procedure in cases of recent cerebral hemorrhage must be done with caution.

We do not wish to leave the impression that the other necessary therapeutic measures in these cases are unnecessary when stellate blocks are done. We also recognize the difficulty in presenting evidence that a procedure is worth while when the findings are based on clinical observations, but certainly there is no reason to abandon the hemiplegic patient to his fate of stumbling, painful and functionless existence.

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DISCUSSIONS ON SYMPOSIUM

DR. KARL B. HANSON, Jacksonville: In my opinion patients with essential hypertension should be observed from the medical viewpoint for a period of several months before surgery is considered. This course fits in with the present trend to be increasingly strict in the selection of patients for sympathectomy. It is the belief of Dr. Richard Lyons, professor of medicine at the University of Syracuse, formerly at the University of Michigan, that physicians should have a healthy skepticism about surgery for hypertension. It is my opinion and his that in those cases in which progressive hypertension of the essential type is present, surgery should be considered. The patients should be talked to at length in an effort to help them with their emotional conflicts and problems, and if these problems appear to be of great importance, it might be wise to seek psychiatric help.

I have had very satisfactory results with the use of potassium thiocyanate. The results seem to be comparable to those recorded for surgery or other therapy. My tendency has been to use this preparation for patients with symptoms resulting from the hypertension. It is most important when using this drug that the patient be carefully followed at not more than monthly intervals, and the blood level should be watched and kept between 7 and 11 mg. per hundred cubic centimeters. If the blood level is allowed to get up to 40 mg., death may be expected. Levels around 15 to 25 mg. often lead to severe toxic symptoms. I have used rutin for some time. Hypertensive patients having elevated petechial indexes by the Gothlin technic should receive this drug before thiocyanate is given, or, if the index becomes elevated during treatment with thiocyanate, it should be discontinued and rutin given until the petechial index becomes normal. When rutin is used, the tendency to cerebral hemorrhage is reduced by 80 per cent. The tendency to cerebral hemorrhage occurs in about 10 per cent of those having an elevated petechial index.

I have had some experience with the use of the low sodium diets. The low sodium content of these diets is, I think, the important factor. I have used a low sodium diet as prepared by the Newberg group at the University of Michigan and have had some gratifying results. It is rather difficult to get patients to adhere to these routines for a long period of time. Two patients have had dramatic benefits from the rice-fruit diet.

DR. W. TRACY HAVERFIELD, Miami: I have enjoyed the presentation of these papers and am particularly delighted with the excellent photographs of the retina presented by Dr. Richardson. The new classification of retinal changes serves as a yardstick for the evaluation of changes in the fundus. Upon listening to these papers one cannot help being impressed with the fact that essential hypertension is a disease of civilization and accompanies the development of the frontal lobe in the phylogenetic scale. It therefore leads one to conclude that there is a large neurogenic element in essential hypertension.

Several years ago when an author offered the suggestion that gastric ulcer is largely caused by psychogenic factors, this statement was received with much skepticism. Later, this view gained in favor and has become more and more accepted. Essential hypertension also has a psychogenic factor. May I cite some experiences with prefrontal lobotomy? Many of the patients who previously had essential hypertension were relieved by this operation. My experiences, however, suggest that the improvement may not be permanent. Recently Dr. Gardner of Cleveland in some unpublished experiments showed that section of the hypophyseal stalk resulted in a lowering of the high blood pressure. Also recently Dr. Anderson of Miami observed considerable fluctuation in the blood pressure of a patient in a manic-depressive state. When the patient was in a depressed state, the blood pressure was normal. While in a manic phase, the blood pressure was as high as 250. With the administration of electric shock therapy and the relief of the manic phase the blood pressure returned to normal. Dr. Percival Bailey of Illinois Research Institute presented some experiments which suggest that the cortical representation of the sympathetic nervous system is located on the orbital surface of the frontal lobe. Stimulation of this area has at times resulted in overactivity of the sympathetic system and at other times in cessation of its activity. This variation has materially confused this problem.

I enjoyed Dr. Mathers' paper very much. It is difficult to explain the mechanism when improvement is obtained by stellate ganglion block in patients with long-standing vascular accidents. Improvement may be on a psychogenic basis. I think we can expect the greatest benefit with stellate ganglion block in cases in which neurologic manifestations are due to spasm of blood vessels. I would further expect more relief of pain from injections on the ipsilateral side where the pain occurs rather than on the contralateral side. I would offer for your consideration the thought that sympathectomy for hypertension gains its benefit in a quantitative removal of the sympathetic nervous system rather than in the exact portion removed. The three most widely accepted operations for hypertension have given comparable results. I therefore leave with you the thought that we must look to the brain for the ultimate answer to this problem of essential hypertension.

DR. GEORGE D. LILLY, Miami: I agree with the ideas expressed here, that the hypertensive patient should be seen first by the diagnostician and should be given the benefit of a period of medical treatment. I want to make a plea, however, for earlier surgical consideration. When a definite diagnosis of essential hypertension is made and when the blood pressure remains elevated or becomes progressively more elevated over a period of one year, I think that surgery should be considered. If the surgeon has an opportunity to see the patient before too much arteriolar sclerosis develops, I am sure the results from surgical treatment will be much better.

In selecting patients, I believe that the physiologic rather than the chronologic age should be a deciding factor. We have all examined persons who are chronologically 60 years old, but who compare physiologically with the average person of 40.

Preoperative tests to aid in prognosis as to surgical results have been most disappointing to me. Some of my patients who have responded most favorably to sedation tests, cold pressor tests and tetra ethyl ammonium chloride have been the greatest disappointments, and some of those whose tests indicated the poorest prognosis have had excellent response to sympathectomy.

It is, of course, important to evaluate kidney function and to reject those cases with poor renal function or obvious nephritis. When ischemia of the kidney is encountered unilaterally, I believe that it is important to carry out sympathectomy and nephrectomy simultaneously because in so many of these cases nephrectomy alone does not give the desired response. If the sympathectomy is done at the same time as the nephrectomy, little additional time is consumed, and the patient then will be half finished with the sympathectomy if he has to go through with it later.

One should, of course, undertake sympathectomy for hypertension with the full realization of its hazards and its unpredictable results. The mortality is not important and should not exceed 2 per cent, even in these poor risk patients. One of the most troublesome complications of sympathectomy is intercostal neuralgia; it occurs frequently and is most annoying to the patient. In most instances this condition clears up slowly over a period of months, and by careful avoidance of trauma to the intercostal nerves it can be minimized. Postural hypertension and "blackouts" are passing annoyances which are,

actually, good omens. I have had 2 cases in which peptic ulcer developed after splanchnicectomy, and have attributed this sequela to a vagus preponderance resulting from the surgery. It is possible that we may have to resort to vagotomy at a later stage in such cases. Three of the 26 men whom I have operated upon had impotence which lasted more than three months, and in all this condition cleared up within one year.

I still believe a fair summary of results to be expected from sympathectomy in hypertension is as follows: one fourth of the patients will be restored to relative normalcy; one fourth will be materially benefited; one fourth will have slight symptomatic improvement, and one fourth will receive no benefit from the procedure.

Dr. Joseph W. Taylor, Tampa: Dr. Richardson has so thoroughly covered the field that there is little if anything left to be said. In my opinion the importance of the examination of the fundus of the eye in cases of hypertension is overemphasized. Only recently 2 cases came under my observation, in each of which the patient had a blood pressure of 260 systolic and 120 diastolic. In one case the fundus showed no evidence of pathologic change, while in the other case, there were retinal hemorrhages in the macular region of one eye with almost complete loss of vision and the other eye was normal from an ophthalmoscopic viewpoint. Statistics given by various authors as to the occurrence of retinal sclerosis in general and arteriosclerosis vary. Bud and Moeller estimated 4 per cent and Wagener 80 per cent. Bridgett in reviewing 200 necropsies found that sclerosis of the retinal arteries was present in only 18 per cent of the cases in which gross changes in the aorta and the coronary and cerebral arteries were present.

It might be added that while retinal sclerosis can give no safe indication of the degree of sclerosis elsewhere, its occurrence in the eye almost certainly indicates its presence elsewhere.

Inasmuch as high blood pressure and other heart conditions are in the lead so far as the cause of death, this is a timely subject and I think more time and effort should be spent in studying its cause and treatment.

Again I wish to compliment Dr. Richardson for presenting a most excellent paper.

Dr. Elwyn Evans, Orlando: All papers on this most interesting symposium have been well presented. To those of us who remember the days when we could do practically nothing for the patient with hypertension, results of newer methods of treatment are stimulating. Some say that patients should not be treated unless they are having symptoms. I can see no logic in waiting for symptoms of cardiac or renal failure or signs of cerebral vascular disease before starting treatment. After studying in detail over 200 patients with hypertension operated upon by Dr. Reginald Smithwick, I became enthusiastic about sympathectomy. This, however, was before I knew anything about the rice and low sodium diets. With our present knowledge of hypertension the patient should be given reasonable trial on medical management before being subjected to surgery.

Dr. James G. Lyerly, Jacksonville: I enjoyed these discussions very much. I believe Dr. Haverfield covered everything from the neurosurgical standpoint. There are some points to bring out in reference to the cerebral vascular spasm. Vasospastic conditions occur in the brain which might be relieved by stellate ganglion block. Several cases came to my mind that I have had in the past two or three years. In one of them the patient had repeated attacks of hemiplegia lasting a few minutes and then clearing up. These attacks would occur frequently, and he was watched to decide what was to be done. I had planned on doing a sympathectomy. I thought he had a permanent paralysis. He was hospitalized and I did the stellate block, later removing the stellate ganglion. Shortly afterward Dr. Merritt asked me to see a patient who for a couple of years had had repeated attacks of hemiplegia, occurring frequently, one or two a week. It was evident in our minds that this patient would have permanent hemiplegia with one of these attacks. In order to relieve them I did sympathetic ganglionectomy on the side opposite to that on which the temporary paralysis occurred. This operation was done two years ago. The patient has not had another attack and is getting along well according to the last report.

There are cases in which there is definite spasm which could be relieved by stellate block.

In regard to essential hypertension, I have done all the types of operations described. Dr. Williams gave an excellent description of the operation. At present, the type of operation resembles that of Poppen in which a large chain of sympathetic ganglia is removed. The procedure that removes the most sympathetic nerves and ganglia is the one that gives the best results.

I think the diagnosis and preoperative studies should be placed in the hands of the internists. I want to know what changes have taken place in the patient, especially the changes that have taken place in the heart. I want to know what changes have taken place in the kidneys and the kidney function; the concentration test probably is the most important here. The other tests make little difference. The operation may be performed on patients of different ages, especially under 50. A few of my patients have been over 50. One has to take into consideration the studies as made by the internist, as I have outlined.

Dr. John T. Stage, Jacksonville: For those of us who are interested in anesthesia the problems of carrying the patient through a sympathectomy have advanced with the surgery. The anesthetist realizes that he is facing a specialized task in this type of patient. The contemplated surgery will remove a portion of the nervous system in a patient who is in a state of autonomic imbalance. With this in mind the anesthetist must as always adapt his methods to the surgeon and the technic used. The anesthetist and not the surgeon must accept the responsibility of keeping the patient in physiologic balance on the operating table, and both must combine their efforts postoperatively to carry the patient past the complications that may waylay him.

It is interesting to follow the anesthetist's viewpoint from my experience for the past three and one-half years. My first anesthesias on the hypertensive patient were a combination of high spinal, pentothal and nitrous oxide. Curare had not yet taken its proper place in anesthesia, and the surgeon was using an extrapleural approach and employing the electrocautery throughout the entire operation. This combination offered a nonexplosive mixture, but obviously it also presented the problem of severe hypotension from the effect of the spinal anesthesia. Spinal anesthesia was dropped when curare appeared on the horizon, and it in combination with nitrous oxide and pentothal proved to be satisfactory.

Now the surgeons are reaching as high as the stellate ganglion. This led to the transthoracic approach and again a shift in technic. Although I have used the combination of pentothal, nitrous oxide and curare for intrathoracic work, I believe that endotracheal ether offers the safest anesthesia in an area that is notorious as a hotbed of reflexes. Electrocautery is used for hemostasis on entering the chest, and therefore pentothal, curare and endotracheal nitrous oxide are employed. As the cautery is discarded, the anesthetic is changed to endotracheal ether.

During the course on the table the anesthetist must handle two separate situations. One is that of treating the patient with an open chest, and the second is that of a fluctuating blood pressure. A cuffed endotracheal tube will provide an air-tight connection. Atelectatic areas of lung can be re-expanded with helium. Aspiration will keep the bronchial tree clear. Re-expansion of the lung under positive pressure as the surgeon closes the wound will obliterate dead space in the chest cavity. Bronchoscopy on the table if necessary will help keep the bronchial tree clean. The question of the fluctua-

tions of blood pressure is answered by having a 15 to 16 gauge needle or cannula in place before the operation starts. This provides a means of supplying the patient with intravenous analeptics. Neosynephrine in doses of 2 drops is my choice at present. Blood may be given by this route if the hypotension does not respond to drugs.

Postoperatively the intravenous fluids are kept going for a matter of hours to insure a source of stimulants, plasma or blood. A bedside roentgenogram of the chest is taken as soon as the patient is returned from the operating room. The surgeon, anesthetist and nurse must then combine their talents for the next forty-eight hours. The patient will require close attention as to his blood pressure, pulse and respiration. Oxygen therapy may be supplied if prolonged periods of hypotension occur. He must be moved and encouraged to cough to guard against atelectasis and thrombosis. He may require thoracentesis to combat pneumothorax or hydrothorax. The second stage proves to be more difficult than the first postoperatively for obvious reasons.

In conclusion then, the problem of anesthesia on the sympathectomized patient has been briefly discussed. Close cooperation between the surgical, medical, anesthetic and nursing services will carry the patient through the sympathectomy.

DR. RICHARDSON, concluding: This has been a most illuminating symposium so far as I am concerned. I have learned a great deal from the other essayists. Dr. Taylor remarked about the fact that we may not expect arteriolar changes in the fundus in some patients with hypertension. This is quite true, but I am of the opinion they add much to our information.

DR. STEWARD, concluding: I have enjoyed the papers by the other essayists and the discussions about them. This has been a helpful resume on a problem about which we do not have all the answers. Perhaps some day we will have them.

I thank Dr. Hanson for pinch-hitting for Dr. Harris. I learned only Saturday morning that Dr. Harris would be unable to be here.

DR. WILLIAMS, concluding: I personally have benefited a great deal from these discussions today. I will go away with quite a bit of knowledge I did not have when I came down here. First, I want to thank Dr. Stage for his presentation on anesthesia in sympathectomy. I am tremendously more confident when doing this operation with him or someone of his caliber at the head of the table.

In essential hypertension one should try to differentiate between the mild cases and the early cases. In mild cases the patient should not be operated on; in early cases he should be. If the operation is done in time, the results will be excellent. In order to distinguish between a mild and an early case one must determine whether the disease is progressive. In mild cases the disease is more or less static. The more severe forms of hypertension show a progressive worsening of symptoms, and this progressiveness is probably the most important factor in the selection of cases for surgical treatment.

DR. MATHERS, concluding: I wish to thank Dr. Haverfield and Dr. Lyerly for their remarks on stellate ganglion block. I doubt if one point was made clear, that is the pain complained of in the paralyzed arm. We have called this a causalgic-like pain because of the severe nature of the pain. I do not consider it a true causalgia, but due to the spasticity of the muscles of the part. The object of the stellate block is to relieve some of the rigidity, and when we do that we relieve some of the pain. On some patients a bilateral block works better than a unilateral block.

This is the last of four papers of a symposium on "Hypertension" presented at the second Scientific Assembly at the St. Augustine Convention in April. Published in this issue also are the discussions of the entire symposium and the closing discussions of the symposium speakers.

The first three papers of the symposium were published in August, September and October respectively.

Progressive Spinal Muscular Atrophy

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A Rip Van Winkle who had gone to sleep more than a century ago would awake today to find no essential change in the knowledge of the medical profession concerning many of the muscular atrophies. True, during this span of years, these atrophies have been classified and grouped and have undergone experimentation, but in 1948 the cause and the treatment still are unknown.

It remains that opinions differ on nomenclature, on classification, on symptoms, on diagnosis, on incidence and on prognosis. While some investigators attempt to proffer etiologic factors, others continue to admit to no known cause. Where some have found success with certain treatments, others have found failure.

In the literature, the predominance of confusion is striking. One ruefully faces another of the anomalies which purport the myriad unknowns still in the hands of the medical scientists.

HISTORY

Progressive muscular atrophy was recognized centuries ago. Pictures and images of the muscular atrophies and dystrophies were carved in stone and wood during the fifteenth, sixteenth and seventeenth centuries.[1] Although a general description of these diseases was given early in the nineteenth century by Bell and Rhomberg,[2] the credit for segregation of a special type is given to Duchenne, who in 1849 somewhat loosely described a particular atrophy. His investigations were supplemented in the following year by Aran. Hence it is that progressive muscular atrophy is sometimes known as the Aran-Duchenne disease. Some thirty years after the initial work by Duchenne the muscular atrophies were separated by the supplementations of Cruveilhier, Luys, Charcot and others. During this investigative period, attention was directed to the implication of the anterior horn cells of the spinal cord.[1]

DEFINITION

Progressive muscular atrophy is a chronic disease and is characterized by the wasting of the muscles with paralysis due to the degeneration of the anterior horn cells. Some refer to it as chronic anterior poliomyelitis; others, as wasting atrophy. Although Aring and Cobb[2] believed that amyotrophic lateral sclerosis and progressive muscular atrophy are one and the same disease, other authors[1,3,5] disagreed. It appears, however, that amyotrophic lateral sclerosis can become manifest following the onset of progressive muscular atrophy and so may be a later stage of the same disease.

INCIDENCE

This wasting palsy is a disease of adulthood, usually striking those in the 25 to 45 year age group.[1] Aring and Cobb[2] observed that the onset rarely occurs before the age of 20. It has been diagnosed in men more frequently than in women. Most notable is the fact that this atrophy appears to be nonhereditary; this point is useful in diagnosis. Apparently there is no climatic or seasonal significance.

ETIOLOGY

Regardless of the speculations, there is no known cause of progressive muscular atrophy which has been acceptable to clinicians. Investigations and experimentations practically come to a standstill when it becomes necessary to declare the cause. Because of the dissimilarity of cases, the physician finds that the cause which he attributes to a particular case cannot be ascribed to the succeeding case, nor is it applicable in a case under the care of another physician. It does not even seem to be apparent that there is a central factor running through all cases from which a conclusion as to etiology can be drawn.

Aring and Cobb,[2] while admitting no known cause, were of the opinion that it may be an exogenous toxin. Richards[1] mentioned several causes, among them infectious diseases, especially typhoid, acute poliomyelitis, toxemias, exposure to cold and wet, overexertion, metallic poisoning, especially lead, and great mental strain. Ostheimer, Wilson and Winkelman[4] sought to awaken the consciousness of the profession to the fact that the cause may be syphilis. They leaned heavily on the writings of Raymond, who in 1893 established a relationship between syphilis and

Read before the Staff of the Alachua County Hospital, Gainesville, June 1, 1948.

progressive muscular atrophy, of Dana who in 1905 suggested the probability of all spinal muscular atrophies being due to syphilis, and of Leri who around 1924 wrote "that progressive spinal amyotrophia is always or almost always due to syphilis." Cecil[3] conceded that occasionally syphilis is the cause, and pointed out also that at times the disease follows an early attack of acute poliomyelitis. Charcot and others offered the same opinion, with which Steegmann[7] agreed. Salmon and Riley[8] found in the literature of chronic poliomyelitis references to 56 cases in which there was a past history of acute poliomyelitis. They added 3 cases to this number.

PATHOLOGY

Pathologically,[2] the muscles are wasted and look pink or even yellow; they are traversed by fatty streaks. Microscopically, the fibers look small and show no striations, but large normal fibers may be found among the atrophied ones. Fibrous tissue is increased. Deposits of granular debris may be seen between the fibers; this may be fatty, but no such deposits of fat as are seen in progressive muscular dystrophy are present.

In the case diagnosed by Steegmann[7] as chronic poliomyelitis, he found that the spinal cord showed shrinkage of the anterior horns at all levels, with chronic degenerative changes and loss of cells. This process was associated with pronounced gliosis of the anterior horns, extending into the white matter, increased fibrosis and gliosis around the blood vessels, fibrosis and thickening of the leptomeninges and diffuse myelopathy due to swelling of the myelinated fibers of the spinal cord. He reported that these changes were not accompanied by mobile or fixed products of degeneration.

SYMPTOMS

The onset of the disease is gradual and insidious. The wasting of muscles is accompanied by fasciculations and loss of motor power, namely, flaccid paralysis, and qualitative electrical changes progressing to a reaction of degeneration, according to Wechsler,[4] whose view of the disease is that of a neurologist. Progressive muscular atrophy does not involve the pyramidal tract.[3] Usually the wasting and weakness begin in one hand. The interosseous spaces deepen, the thenar and hypothenar eminences waste, and a "claw hand" results. The palm of the hand is flattened because of atrophy of the lumbricales, and there are hollows between the tendons of the long flexors of the fingers.[2] The process gradually progresses upward and involves the forearm, arm and shoulder. The limb then hangs limply, and there is winging of the scapula.[4] Fibrillary tremors are frequently noted in the muscles involved.

It is possible that fifteen or twenty years may elapse before the patient becomes totally disabled.[5] The disease may remain stationary, show remissions or progressively involve other limbs or parts of limbs.[4] Ultimately the respiratory muscles become involved, and symptoms of bulbar paralysis make their appearance.[2] Although the reflexes of the atrophic muscles may be abolished, the reflexes at uninvolved levels of the cord remain normal because the pyramidal tract is not implicated. No sensory changes occur.[3]

DIAGNOSIS

The line which separates the various atrophies and related diseases is so fine that diagnosis of progressive muscular atrophy is a particularly difficult process. Many of the atrophying diseases are confused with it and present obstacles to the correct diagnosis. The process of elimination, the key to diagnosis, is a precarious one.

Some of the diseases which may be confused with progressive muscular atrophy include:

1.—Amyotrophic Lateral Sclerosis. This may be called an advanced stage of progressive muscular atrophy rather than an entity in itself. It progresses more rapidly than progressive muscular atrophy and always implicates the pryamidal tracts.[3]

2.—Werdnig-Hoffman Paralysis. This hereditary infantile type of atrophy involves the trunk muscles, producing a scoliosis.[5] The atrophy is more or less symmetric and also involves the extremities.[4]

3.—Syringomyelia. Although marked by muscular atrophy, this disease is accompanied by pain, by loss of the sense of temperature in the atrophic segments and by sensory change.[4,9]

4.—Muscular Dystrophy. This conditon is classed as a hereditary disease, presenting no fibrillations and a degeneration long after the onset.[1] Very often the dystrophies occur in children.[4]

5.—Syphilitic Endarteritis. While giving a picture of chronic poliomyelitis, this disease is limited to the anterior spinal arteries and anterior horns. It progresses more rapidly; there are apt to be other signs of neurosyphilis, especially pupillary changes, and the history and serologic reactions often give positive evidence.[4]

Progressive muscular atrophy must also be dif-

ferentiated from disuse, trauma, tabes dorsalis, neuritis, poliomyelitis,[2] cervical hypertrophic pachymeningitis, cervical rib and cord tumor.[4]

TREATMENT

Because of the intimate interdependence of etiology and treatment, one must unfortunately suffer the consequences of the other. In the case of progressive muscular atrophy no known etiology equals no known treatment. It is evident in the literature that some physicians have had success with certain therapy; others hopefully employing the same therapy have met only failure.

Meller[10] reported some success with the administration of vitamin E to 14 patients suffering from varying types of progressive muscular atrophy. Three patients showed apparent recovery, 7 showed definite improvement, and 4 failed to respond. He stressed the need for large dosage over a long period of time and suggested the following: 100 mg. daily of alpha-tocopherol intramuscularly for six to eight weeks or 150 to 200 mg. of the drug orally over a similar period of time.

Woltman and Butt[11] failed to get good results with vitamin E in 8 cases of progressive muscular dystrophy and 6 cases of amyotrophic lateral sclerosis. They reported that they had found no conclusive evidence that vitamin E alone or in combination with vitamin B_6 and other vitamins is of benefit in amyotropic lateral sclerosis, progressive muscular atrophy or progressive muscular dystrophy.

Doyle and Merritt[12] also reported failure with their use of vitamin therapy. In 12 cases of various types of muscular atrophy, including 1 of progressive muscular atrophy, they were unable to produce improvement or to arrest the course of the disease.

Schwab and Chapman[13] found that neostigmine increases fibrillations in progressive muscular atrophy. These authors did not, however, favor its use even in mild cases because of dyspnea and cyanosis.

Treatment, according to Wechsler,[4] is essentially symptomatic. He listed rest for the atrophic part and avoidance of exertion as helpful, electrical treatment as doubtful and possibly harmful, massage as useless, vitamin therapy as unencouraging, and orthopedic appliances as possible.

REPORT OF CASE

B. A. G., a 32 year old white farmer, first came to me in January 1948 complaining of paralysis of his right arm. There was no history of a birth injury. During the first year of life he suffered from thrush and cholera infantum. At the age of 2 he had severe pain in both legs, which were swollen and extremely tender to the touch. He was unable to walk. The diagnosis was "rheumatism," and the duration is unknown. At age 8 he had "kidney trouble" with edema and mild anuria. In the following years he was a "sickly child" according to the family. Between the ages of 10 and 14, he suffered with measles, a fractured right collar bone, a discharging pilonidal sinus, malaria and mumps with resulting orchitis on the left side. At 18 he contracted whooping cough. There followed a period of several years when he was in comparatively good health with the exception of pain and swelling in his feet after he had plowed all day.

Eleven years later at the age of 29 he again suffered with rheumatism with painful, swollen and tender joints. The pain traveled from one portion of the body to another and was accompanied by high fever. A diagnosis of "rheumatic fever" was made. Upon his physician's advice he had his teeth repaired, but refused to have a tonsillectomy. After the pain and swelling had disappeared, he complained of feeling tired and listless.

Slightly more than a year later, in January 1946, he first noted weakness in his right hand when he was unable to grasp a hammer without it twisting about in his hand. Three months later he noticed that his right arm was becoming smaller and that it became more difficult to feed himself. This weakness and atrophy were gradual in development and were explained by the patient's wife as follows: "It worked so slowly that we had to think back to see what he could do a month ago in order to tell if he was getting worse." In December 1946 he could still write his name. His right hand was not completely useless until March 1947. In June 1947 he noticed weakness in his left arm, and after a month, it too was useless for lifting. By the end of the following November he was unable to feed or bathe himself. In December his legs became weakened, and he required assistance in walking. It was impossible for him to climb stairs. There were no sensory complaints and no aphasia. The family history was noncontributory.

On examination, the blood pressure was 140 systolic and 90 diastolic, temperature 98.6 F., pulse 84 and weight 152 pounds. Sensory examination with different stimuli gave normal findings. Pronounced weakness and muscular atrophy of the upper extremities and some weakness in the muscles of the right leg were present. Examination of the reflexes showed the biceps and triceps jerks to be absent on the right and sluggish on the left. Knee and Achilles jerks were hyperactive on both sides. The Babinsky reflex and ankle clonus were negative.

Urinalysis, chemically and miscroscopically, gave negative results. The blood Kahn reaction was negative. Blood studies revealed hemoglobin, 14 Gm.; red blood cells, 5,350,000; white blood cells, 11,350; hematocrit reading, 50 cc. per hundred cubic centimeters of blood; and differential count normal. Spinal fluid examination revealed clear fluid with no cells, no increase in pressure and protein 56 mg. per hundred cubic centimeters; the Kahn reaction was negative.

Symptomatic treatment was begun, and injections of vitamin B complex were given.

The weakness slowly progressed, and on March 30 the patient noticed that his voice was not as strong as formerly, especially when he was singing. Examination at this time indicated little change except that the knee and the Achilles jerks were now diminished on the right, but normal on the left. The entire musculature of both upper extremities was wasted; both arms and hands were flaccid; and winging of the left scapula was present (figs. 1 and 2). Blood studies at this time showed hemoglobin, 14.9 Gm.; red blood cells, 4,990,000; white blood cells, 11,700; sedimentation rate, 3 mm. in one hour; differential count normal; segmented forms, 66 per cent; juveniles, 1 per cent; stabs, 4 per cent; eosinophils, 2 per cent;



Fig. 1.—This photograph shows the atrophy of the shoulder and deltoid areas and the complete flaccidity of both arms and hands, which are supported by arm rests (March 1948).



Fig. 2.—This photograph shows the atrophy of both shoulder and deltoid areas and also winging of the left scapula (March 1948).

monocytes, 6 per cent; lymphocytes, 21 per cent; nonprotein nitrogen, 44.5 mg. per hundred cubic centimeters; creatinine, 0.8 mg., and blood sugar, 58 mg. The blood Kahn reaction was negative. The blood sugar was 83 mg. when the test was repeated ten days later.

On May 6, the patient showed definite paralysis of the muscles of respiration and was admitted to the hospital, where oxygen and coramine were given to no avail. He expired from paralysis of the respiratory muscles on May 9.

COMMENT

In reviewing the past history of this case, it is impossible to say that the patient at the age of 2 did not have poliomyelitis, which was diagnosed as rheumatism. The family stated that the legs were swollen and extremely tender to the touch and that the child was unable to walk. In view of this illness, one cannot say that this case does not then fall into a category with chronic poliomyelitis. It seems, however, that a logical discussion of the case would place it as progressive spinal muscular atrophy since there was no sensory involvement and no involvement of the pyramidal tract was present. The difference apparently between chronic poliomyelitis and progressive spinal muscular atrophy is that of a past history of acute poliomyelitis.

The patient was treated symptomatically and also specifically with injections of vitamin B complex. Following these injections there were no noticeable objective changes, but the subjective changes were great. For this reason this medication was continued until the patient was admitted to the hospital with respiratory failure.

SUMMARY

A review of the subject of progressive spinal muscular atrophy with a discussion of differential diagnosis is presented. Stress is placed on the continued enigma shrouding the various atrophies, most of which are without known etiology and treatment.

A case of progressive spinal muscular atrophy which terminated fatally because of bulbar paralysis is reported.

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Points on Immunization Procedures and Quarantine

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I have been asked to consider the latest developments in communicable diseases and, in addition, to make some special reference to quarantine. It behooves me to start with the simplest of all immunization procedures on the list—vaccination.

IMMUNIZATION PROCEDURES

The epidemic of postvaccinal encephalitis which appeared in Holland, Denmark, England and elsewhere caused wide apprehension as regards the long-tried procedure of vaccination against smallpox. In England, it gave rise to an order in Council, discontinuing the use of the multiple puncture and instead recommending the single puncture method. In the United States, there have been approximately 82 deaths caused by this condition. Probably the last, or eighty-second such death in this country, was one that occurred on my own service. Millions have been vaccinated, and the Public Health Service does not see fit to change its recommendation from the multiple to the single acupuncture method. When one considers that millions of people are vaccinated, 82 is a minute proportion to get complications.

The postvaccinal encephalitis could not have been due to the vaccine virus because vaccine made in Spain did not create the condition there, but did cause encephalitis elsewhere. Some have thought that something in the individual which happens to be present in the populace is lit up at the time of vaccination. The idea that another virus is activated rested upon the herpes experiments of Levaditi, Lepine and Schoen (1929). A better hypothesis considers the cause to be an inflammatory reaction in the central nervous system induced by the union of virus (antigen) and specific antibodies. The definite inoculation period of ten to twelve days tends to support this theory. Thus, the central nervous system may be sensitized, as a consequence of which there is antibody production associated with anaphylactic reaction, such as frequently follows any contagious disease. Such cerebral complications after vaccination were noted by Freud as far back as 1891.

Vaccination against smallpox can be done any time during an epidemic, but routinely any time after the cord falls off, and should be done at least before three years of age. Routine vaccination may be done within the first three months of life. Revaccinate at six and twelve years of age and during an epidemic. It is my opinion that vaccination against smallpox should never be done in other than a healthy, normal person and that some time (three months) should elapse between it and other types of vaccinations.

In the past few years, I have worked with a committee under the chairmanship of Dr. V. K. Volk of Saginaw, Mich., whose members have been trying out multiple vaccines. At first, we employed combinations of several vaccines, those of whooping cough, tetanus, diphtheria, scarlet fever and typhoid fever, but these injections unfortunately caused marked reactions, so much so that we had to stop and determine the cause. It was concluded that the naked scarlet fever toxin was the factor responsible for the trouble and this was removed. The typhoid fever vaccine was also taken out because it was not necessary for all people everywhere to have this, although in Florida, particularly in districts where there are difficulties with the water supply and in times of storms, this measure might be necessary.

The investigation referred to has been going on over four years under controlled conditions. It has been found that immunization can be established by the injection of three combined vaccines — diphtheria, tetanus and whooping cough—without too much reaction, and it was concluded that this procedure could be recommended.

There were several problems to consider. Does a booster dose inoculated subsequently cause a reaction? Is it best to have a booster dose that is analogous with the original antigen, and how soon should it be given? These questions were

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Read before the Florida Health Officers' Society, Third Annual Meeting, St. Augustine, April 11, 1948.

not exactly answered by trial, although it was concluded that in the case of tetanus, a booster dose should be injected within a year after the primary injection, or at any time after a tentative exposure to tetanus.

So far, nothing has come to our attention that would deter us from the use of booster doses with but one exception. Byers, at the meeting of the American Pediatric Society, reported 15 cases wherein the patients had received injections of whooping cough vaccine following which they had convulsions with encephalitic changes at intervals varying from a few hours on. Twelve received fluid toxoid. The encephalitis was irreversible and in many instances complete. This report was commented upon by Sauer and others, including Buchanan of Chicago, the former denying, the latter confirming its possibilities. In my practice, I have never observed such a condition, although I have cared for many infants ill with whooping cough in whom encephalitis occurred. I communicated with all the local pediatricians, however, and was able to collect 5 or 6 case records of patients experiencing unquestionable reactions after whooping cough vaccine (38 patients as of June 23, 1948). These reactions were not connected with the products of any particular firm, and it made no difference whether the vaccine was grown on human or sheep blood. Convulsions appeared shortly after the injection, and in the last of these patients that I observed, there was a temporary hemiplegia which disappeared in a few days. I investigated every case reported, and in every instance, the child was found to be suffering from a concurrent disease at the moment he was injected and even had fever at the time. From these reports, it could be demonstrated that no patient had an irreversible attack of convulsive seizures and in every instance, the reaction appeared in a child who was ill at the time of inoculation. Taking the millions that have been injected and the few reactions that have been described, the committee referred to will probably investigate further and still recommend the use of whooping cough vaccine as heretofore.

There is a commendable tendency to decrease the number of Schick tests in sensitized persons. For instance, it is wholly unnecessary to test a baby after one year of age. His reaction will be positive anyway, and if he is tested before one year of age, it may be negative; thus one may get spurious information. It is much better to immunize every child without doing a Schick test at all. If, however, a Schick test must be done, it should be done with care. If it is in the younger age group, one may omit the control and inject only once. It is also unnecessary to do a Schick test to determine whether a person is immunized. It would be better to give a booster dose and to avoid another test.

If a Schick test should be persistently positive, it is necessary to know whether the reaction is nonspecific and to do a control test. For public health purposes, then, it is much better to get the physician into the habit of giving booster injections within certain years, at school levels for instance, and to ignore the Schick test and so many injections, although in private practice there still is the tendency to Schick test.

There is no particular reason to immunize children routinely after ten or twelve years of age. In districts where there has been diphtheria, there usually is a negative reaction, the children having been immunized by subclinical attacks. The only place where a Schick test would be indicated later in life would be in an institution where a case of diphtheria has occurred and where localization is desired. This observation does not mean that it is foolish to do Schick tests as in private practice, where the objective is to check the case 100 per cent and where the information is desired to that end. From a public health standpoint, the objective is to protect at least 75 per cent of the population, and in this way diphtheria will be eradicated.

There are many other vaccines. Rabies vaccine should be used if the need arises, but a little care should be taken to rule out its use in those who are not in need of injections. If the subject shows any reaction such as vomiting, pain over the liver or a rash of an allergic type, the injection should be discontinued to avoid a fatal toxic neuronitis (rabies paralysis).

Tuberculin or BCG vaccine should be used when the time arrives, but the material should be obtained from a source approved by the United States Public Health Service.

Under certain circumstances, vaccines for typhoid fever as well as for cholera, plague, yellow fever and Rocky Mountain spotted fever are necessary in the districts involved. It is a waste of time to give staphylococcus vaccine and tularemia antiserum.

I cannot recommend the use of scarlet fever immunization as yet. Reactions to the toxin are too severe, and although scarlet fever has been wiped out among nurses and physicians in my own institution, who are routinely immunized if Dick positive, I still do not recommend it as a public health measure. In recent tests, I and my staff have obtained negative reactions in patients given injections of smaller amounts of purified antigen. This may be the answer to the problem of scarlet fever, and our next experiment would be to determine whether the antigen does protect.

Much work has been done on the common cold, but there is nothing conclusive. Research has been made on influenza, but even the workers themselves are uncertain about this vaccine and continue describing new strains each day.

There is an erysipelas vaccine which needs only to be mentioned to be dismissed. There is a gas gangrene serum which is employed for clinical use with a questionable value. There is good evidence that pertussis hyperimmune human serum may be of value in treatment. Mumps vaccine has been attempted. It is not in the stage where it could be recommended. Neither does Stokes think that the measles vaccine is of proved value. Human measles and whooping cough convalescent serums are of definite value.

QUARANTINE

There has been a great change in quarantine procedures in the past few years. Doubtless many of you have been perplexed by the many questions that you have been asked in relation to quarantine and isolation. There are differences everywhere. There are local prejudices and local exigencies of which the public health officer must take cognizance. He must change unreasoning prejudices to his own advantage without too much fanfare.

There is no good reason why the personnel of a general hospital should be thrown into a state of panic when one of its patients is found to be suffering from a common contagious disease. This is often the case, and a demand for immediate removal of the patient to a public contagious disease hospital is customarily made. This attitude is unreasonable since patients with diseases equally contagious (pneumonia, tonsillitis, streptococcic sore throat, various skin infections and suppurative conditions) are being treated in wards with other miscellaneous disorders without any isolation whatever.

It is unfortunate that there are no uniform rules governing the control of common contagious diseases for restrictions are often instituted in a community without any scientific basis to support them. All patients with ordinary contagious diseases, except measles, chickenpox, smallpox and epidemic diarrhea, can be adequately cared for in any general hospital which practices aseptic technic. When there are no susceptible contacts in the house, patients do not even need to go to a hospital and can be cared for at home. The day of the large contagious disease hospital maintained at public expense has passed. What is now needed is better training of medical personnel in aseptic technic in each and every hospital.

The restrictions which surround funerals should be lifted. There is no reason why a home or a church funeral should not be held if the body is contained in a closed casket. Victims of smallpox, plague and some new virulent epidemic diseases are the only ones for whom there should be private funerals.

The administrator of a hospital must decide what is most economical for his particular situation. If he decides to admit patients with a contagious disease to a general hospital, then all patients admitted, whether having a contagious disease or not, must be handled with aseptic technic. This may be found more expensive than if patients with contagious diseases were isolated in separate quarters and aseptic technic practiced only in those places. Where the demand for beds for patients with contagious diseases is great, it may be less expensive to isolate them away from the other patients. Where the hospital is small, sporadic cases can be isolated with strict aseptic technic. When this procedure is adopted, it requires nursing services, the cost of which may become burdensome to the patient's relatives; hence, it is practical to isolate the occasional patient at home, unless he needs hospital attention.

There are very few diseases that need to be placarded. In my opinion, cholera, diphtheria, plague, smallpox, yellow fever, and epidemic diarrhea are about the only ones. Patients with diseases like dysentery, gas gangrene, impetigo, influenza, measles, pertussis, scarlet fever (which includes streptococcic sore throat, acute tonsillitis and pharyngitis), tuberculosis and typhoid fever should be isolated from persons who are susceptible. Those with some diseases like chickenpox need not be isolated at all, and the susceptible person should be allowed to get the disease.

This question is a subject of the official report of the American Academy of Pediatrics. It also has been the subject of an official report of the American Public Health Association. There are slight differences between the reports on these conditions, and the chances are that representatives of both of these organizations serving on a suggested joint committee will reconcile these differences and make commendations accordingly.
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The Diagnosis of Secondary Syphilis

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The diagnosis of syphilis has presented many problems from the time it was first recognized by ancient physicians. Equally difficult with these problems has been the proper nomenclature of the various stages or manifestations that the disease goes through from the time the infection is acquired until it is cured or becomes latent in the individual. In keeping with the various trends taking place in medicine, first there was a swing to nothing but physical findings and then, when Wassermann came out with complement fixation, there was a reversal to a serologic diagnosis of syphilis. This opinion has been foremost and has dominated the diagnostic field up to the present time. Wassermann's serologic reactions were substantiated and modified by many investigators. Kolmer developed a technic based upon Wassermann's fixation test. Shortly afterward Kahn devised a different serologic test based upon the agglutination factor. Both tests are accurate, sensitive and reliable, depending upon the skill of the serologist. At the onset of World War II and the increase of syphilis around camps and cantonments, the United States Public Health Service launched a comprehensive program not only to deal with the control of venereal disease, especially in the infectious stage, but also with proper, adequate medication for those persons requiring treatment.

With the advent of penicillin for the treatment of syphilis, it was recognized by such early investigators and eminent authorities as Evan Thomas that a new era in the treatment of syphilis was at hand and probably a new terminology and diagnostic procedure would have to be considered. Due to the changing influence penicillin has had on the cutaneous lesions and the serologic reactions, and the rapidity of the disappearance of clinical symptoms, with the masking effect of penicillin given for diseases other than syphilis, it is apparent that the clinician must rely more and more on a composite picture and the evaluation of the patient as a whole rather than one single factor.

The diagnosis of secondary syphilis is one of extreme importance to the community in that the individual requires early, adequate treatment to prevent spread, and also, to the individual in that he or she receive proper care and treatment to prevent sequelae or complications that occur in three fourths of untreated cases. We base our diagnosis on a number of factors that as a whole will or will not substantiate the diagnosis. First of all, we consider a history of extreme importance. This history must be all inclusive and especially concerning the sex behavior of the patient. This as a whole establishes a pattern of life, for we know the manner in which people live is of primary importance as to the diseases they acquire. Coupled with this information, we know that approximately 55 per cent of the persons who have sexual contact with the victim of an infectious case of syphilis become infected.[1] Also, if there is a history of recent administration of penicillin, it might so mask the clinical picture at the time that it appears the patient is not infected. Such a case should be followed preferably for nine months with a serologic test at monthly intervals, together with a complete clinical examination to observe the occurrence of infectious lesions.

In taking histories there are symptoms of primary importance that are frequently overlooked. The occurrence of a lesion, any sore that occurs on mucous membranes or the genitalial area even if it disappears spontaneously, should

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be regarded with suspicion and followed with repeated examination. Rash is frequently forgotten by the patient, or may be attributed to drinking carbonated beverage or to heat. Sore throat is a particularly frequent symptom and one that is most frequently overlooked or ignored by the busy clinician. Joint pains, headache and a lassitude follow closely, at the onset, after the person is infected. Physical examination is of extreme and utmost importance. To achieve this the patient must be nude, and the surface of the body must be evaluated as a whole and not as a part. The rash of syphilis as a rule follows definite patterns; yet it may imitate many of the common skin diseases. A darkfield examination is performed upon every lesion no matter how insignificant. The sentinel lymph adenitis that one finds near lesions or the general lymph adenopathy are added findings. On moist surfaces of the body and mucous membranes, the most insignificant lesion may be condyloma or mucous patches.

Serologic examination is not here considered last because of its lack of importance but in the proper order of any diagnosis in which the laboratory merely corroborates the history and the physical findings. There are many diseases that will cause a positive serologic reaction, that is with the Kahn test. We like the quantitative Kahn test because it is fairly well standardized, sensitive and specific. When one does a series of tests, it is wise to order the same test and not change to the Eagle, Mazzini or Kline test. If, from time to time, one wants a check on the Kahn agglutination test, then it is well to get a Kolmer test, which is a complement fixation test. If there is disagreement in the results, one can then suspect a false positive. As a rule dilution will not be so high in false positive serologic reactions and will vary greatly in reading if the test is repeated at intervals of five to seven days. In a survey of an Eastern college Eagle observed that a false positive may occur less than once in 4,000 people.[2] One must not lose sight of the fact that the serologic tests on these 4,000 people represented a survey of apparently healthy persons and not clinic patients among whom one would frequently find diseases which would give rise to a positive blood reaction and give a great deal higher incidence. The high dilutions do not go hand in hand with the acuteness or severity of the infection, but with high dilutions one frequently sees all the signs and symptoms of syphilis. So we can expect to see in secondary syphilis a fairly high dilution, 8 to 32 Kahn units or higher.

SUMMARY

In summary, it is imperative to emphasize the three factors that are most important and should be gone into thoroughly before a diagnosis of syphilis is made, namely, history, clinical findings and serologic examination. Above all, do not lose sight of a great imitator—syphilis.

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ABSTRACTS OF MEDICAL ARTICLES

BRONCHIECTASIS, A NEGLECTED DISEASE. By Julian A. Rickles, M.D. South. M. J. 40:551-554 (July) 1947.

Surgical therapy rather than medical management of bronchiectasis is advocated by the author. Since in most instances medical treatment is unsatisfactory and accompanied by a high rate of mortality, the more radical form of treatment is favored in dealing with this chronic disease of young persons. It has been shown by many different investigators that almost 40 per cent of medically treated patients will be dead in five years and few will remain alive after ten years; in contrast, the rate of mortality with lobectomy has been reduced to around 2 per cent. Pulmonary resection is tolerated well, especially by children and young adults, and it is now possible to remove only the diseased portions of affected lobes.

The disease is divided into the congenital primary type, which usually remains asymptomatic until infection occurs, and bronchiectasis of a secondary nature which may eventually result from anything that narrows the lumen of the bronchus. The author points out that the local symptoms may depend upon three factors: (1) the degree of associated pulmonary involvement; (2) the severity of the bronchitis; (3) the

size, number and location of the cavities. A cough, usually accompanied by fetid breath and sputum varying in amount from a few cubic centimeters to over a quart a day, is listed as the outstanding symptom. It is noted that hemorrhages, usually not severe, occur more frequently than is commonly believed and that it is important to realize hemorrhage may indicate bronchiectasis as well as cancer or tuberculosis. Fever, chills, sweats and recurring "pneumonias" also characterize the disease.

With ordinary roentgen studies of the chest suggesting bronchiectasis with about 75 per cent accuracy and bronchography and bronchoscopy establishing the diagnosis, the author concludes that this condition need no longer be considered a neglected disease. He observes that the present low mortality rate associated with pulmonary resection places the responsibility directly upon the general practitioner, the internist and the pediatrician, under whose care patients with this disease first come, and he bespeaks the benefit of surgical therapy for those patients with sufficient healthy pulmonary tissue and no systemic contraindications.

MULTIPLE CARCINOMATA OF THE UTERUS. By Homer L. Pearson, Jr., M.D. South. M. J. 40:728-732 (Sept.) 1947.

A case of squamous cell carcinoma of the cervix and adenocarcinoma of the corpus of the uterus is reported which illustrates the care required in establishing a diagnosis of two different tumors in one and the same uterus. The characteristics of the several types of carcinoma of the uterus are described, and the frequency with which they are observed in the cervix and the corpus is discussed. The problem of the occurrence of multiple tumors is presented in some detail.

In accepting the evidence of multiple tumors of the uterus one should ask not only for different architecture and anlage, but also for spatial separation of tumors, the author observes. In summary he states that proof of separated and localized origin identifies the independency of two malignant lesions in the uterus as multiple, but if both tumors have been melted together, the multiplicity can be granted only if one end of the tumor shows different histologic structure from the other and only if the melted area offers a mixture of different epithelia. With different tumors of identical structure, he adds, multiplicity can neither be denied nor admitted.

FERTILITY IN WOMEN: THE LENGTH OF TIME REQUIRED TO CONCEIVE. By A. W. Diddle, M.D., R. W. Jack, M.D., and R. L. Pearse, M.D. Am. J. Obst. & Gynec. 54:57-61 (July) 1947.

Of 318 pregnant married white women, ranging in age from 16 to 42 years and living in a semitropical climate with husbands who were members of the armed forces and at home two nights out of three, 86 per cent of the 261 primigravidas and 64.9 per cent of the 57 multigravidas conceived. Contraception was not employed by these couples, and sexual union was experienced on an average of two to three times a week.

A study of available data on 481 other pregnant and 393 nonpregnant women, using no contraception, when correlated with the other data, substantiated the conclusion that the majority of fertile couples can expect pregnancy to begin within twelve months after marriage. Multigravidas will, however, require a slightly longer time to conceive than primigravidas because of a period of relative sterility following the previous pregnancy.

MANAGEMENT OF ACUTE TOXIC NEPHROSIS. By Victor H. Kugel, M.D. Am. J. Med. 3:188-205 (Aug.) 1947.

This paper is restricted to discussion of the acute renal injury resulting from carbon tetrachloride poisoning, hemolytic transfusion reaction and crush syndrome. Illustrative cases reflect the lack of any specific therapy, the problems of management and the fallacy of imputing therapeutic value to medical and surgical measures currently advocated.

The basic therapeutic approach suggested in the management of acute toxic nephrosis is the selection of a plan that will tide the patient over the acute renal injury and that will favor spontaneous recovery. In contradistinction to the generally accepted therapy of intravenous fluids, challenged by the author as being both harmful and ineffective, it is believed that fluid restriction is the keystone to such a plan. An initial daily intake of 700 cc. of physiologic saline, not necessarily intravenously, is advocated, to be increased or decreased as clinical observations indicate. Other features of management and various therapeutic adjuvants are discussed.

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The Journal of The Florida Medical Association

Owned and published by Florida Medical Association, Inc.
P. O. Box 1018 (Fla. Theater Bldg.)
Jacksonville 1, Florida

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AN ANSWER TO MR. TRUMAN
THE EWING REPORT

Some months ago President Truman asked Mr. Oscar Ross Ewing, Federal Security Administrator and Supervisor of the United States Public Health Service, to formulate a ten year health plan for the nation. In May, Mr. Ewing called a National Health Assembly for the ostensible purpose of obtaining advice from physicians and other experts. The assembly, which was thought by some to have political motives, concluded that the United States needs some type of medical insurance, but made no recommendation as to what type.

Now, after six months' study, Mr. Ewing has made up his mind. In a 186 page report recently handed the President, he comes out flatly for compulsory government health insurance. But almost no one is surprised.

A lawyer, and formerly assistant chairman of the Democratic National Committee, Mr. Ewing has much to say about the nation's health, or rather the lack of it. He estimates that every year 325,000 Americans die for lack of medical and health services, namely: 120,000 from communicable diseases that might have been cured, 115,000 from cancer and heart disease that might have been prevented, 30,000 maternal and infant deaths that are unnecessary, and 60,000 from other causes.

Mr. Ewing further contends in his report that only 20 per cent of the nation's families can afford all the medical care they need, although the United States is well supplied with doctors and hospitals, and he adds that about half of the families, those with annual incomes of $3,000 or less, find it hard if not impossible to pay for even routine medical care. Thus he comes to the conclusion that the nation needs a lot more medical and health services than it already has, and he asserts that by 1960, exclusive of government health insurance, the federal government should be spending $2,313,000,000 per year, while state and local governments should be spending $1,795,000,000 yearly.

Compulsory insurance, Mr. Ewing asserts, is necessary. Voluntary plans are not and never will be enough, for, says he, only about half the families of the nation can afford even moderately adequate health insurance on a voluntary basis.

Let's examine the record.

The plan which Mr. Ewing is recommending does not differ greatly from that which Great Britain has adopted recently. He expects physicians to cooperate with a scheme which is proving to have many pitfalls. Furthermore, many of the statistics and arguments which Mr. Ewing presents have been refuted and answered by the carefully prepared report of the Brookings Institution, commented on editorially in the August through November issues of The Journal.

No one knows what a nationalized compulsory health insurance program would cost, for "guesstimates" vary widely—between $50 and $80 per person per year. Accepting $65 per person per year, which is slightly less than the guess of the National Industrial Conference Board, as a conservative estimate, Dr. Paul R. Hawley recently has pointed out that the cost to a family of four would be $260 per year compared to the present average cost of $62 for Blue Cross—Blue Shield protection. Even if the head of the family paid only one third of the cost under goverment insurance, it would cost him about $87 per year. And that does not take into account the additional cost to the already burdened taxpayer.

During the past eight years Blue Shield has increased its membership 3,500 per cent and with Blue Cross now has some 37,500,000 members. Plans for wider and more adequate coverage have been made and are expected to become a reality soon.

It would appear that the majority of reasoning people will find little or nothing in the reasoning, statistics or conclusions of Mr. Ewing with which they can agree. Here is the lay opinion of a would-be reformer and socialist who may find that he cannot fill a job which requires a person with scientific knowledge and wide experience.

President Truman's gullible acceptance and hearty promotion of this dangerous form of legislation is to be noted. The answer from organized medicine should be clear and straightforward. Negative action, rebuttal and criticism will not be effectual. An adequate, comprehensive Blue Shield—Blue Cross program with central coordination and wider coverage appears to be the answer to the problem.

THE HAWLEY SPEECH

Every member of the Association will wish to keep constantly in mind the highlights of the address made by Dr. Paul R. Hawley at a conference of state medical association officers in Chicago recently. So important was the speech that a copy was mailed to the membership with the expectation that all would familiarize themselves with it. Whether or not you read it in its entirety and made a study of it at the time you received your copy, it is timely now that each and every member take stock again of Dr. Hawley's analysis of what portends.

Accordingly, an abstract of the address, setting forth the salient features which hold high import for you and every member of the medical profession, has been prepared, with comment, by the Assistant Editor. It is published among the Commentaries in this issue of The Journal.

The dangers, fast becoming critical, that threaten the free practice of medicine in this country—the last hope of American medicine—the attitude of Labor—the demand that has become a roar for more comprehensive medical care and for an effective means of budgeting its costs—the future of voluntary prepayment plans—the tragedy of socialized medicine that even now stalks at our doorstep—what of these? To what extent will organized medicine be responsible if the curse of socialized medicine comes? Will wisdom or emotion decide the issue? How long could you hold out in a strike against the government? What can the medical profession do to meet the issue and avert imminent disaster?

Read the abstract of Dr. Hawley's analysis of the crucial situation and Dr. Merritt's comment thoughtfully and carefully. There is no time for apathy or indifference.

BROOKINGS REPORT CONCLUSIONS ON COMPULSORY HEALTH INSURANCE

Though one hardly expects to witness the phenomenon suggested, the following editorial comment[1] bears repeating: "Moreover, as has already been mentioned, the agency for the study of medical care in the Federal Security Agency has been from the first an agency of propaganda rather than an agency for scientific study. The report on 'The Issue of Compulsory Health Insurance' by George W. Bachman and Lewis Meriam, published by the Brookings Institution, should bring a blush of shame to the cheeks of even these hardened advocates of government medicine. Surely they will recognize now the difference between a scientific objective study of dependable evidence and the kind of promotional publicity that they have been turning out in pseudoscientific documents since they first began collecting a living from government sources."

In this fourth and concluding editorial on this very able study, commonly called the Brookings Report,[2] it is deemed proper to quote the

1. The Brookings Report on Compulsory Health Insurance, editorial, J. A. M. A. 137:536-539 (June 5) 1948.
2. Bachman, George W., and Meriam, Lewis: The Issue of Compulsory Health Insurance, Washington, D. C., The Brookings Institution, 1948.

conclusions pertaining to compulsory health insurance:

> 9. Compulsory health insurance would necessitate a high degree of governmental regulation and control over the personnel and the agencies engaged in providing medical care. This field of regulation and control would be far more difficult than any other large field previously entered by the Government, and past experience with governmental regulations and control in the United States causes doubt as to whether it encourages initiative and development.
>
> 10. The problem of eliminating politics from Government administration is extremely difficult. It does not seem probable that politics could be eliminated from medical care supplied under a governmental system.
>
> 11. Compulsory insurance would inject the Government into the relationship between practitioner and patient. A real danger exists that Government actions would impair that relationship and hence the quality of medical care.
>
> 12. The administration of compulsory insurance would require thousands of Government employees for accounting, auditing, and inspection and investigation.
>
> 13. The cost of medical care presumably would increase because of (a) administrative expenses; (b) the tendency of insured persons to make unnecessary and often unreasonable demands upon the medical care services; and (c) the tendency of some practitioners and agencies to take advantage of the system for their own financial advantage.
>
> 14. The adoption of compulsory insurance would not immediately make available adequate service for all, because there are not at present the facilities nor a sufficient number of trained and experienced physicians, dentists, and nurses to meet the demand which would result from compulsory insurance.
>
> 15. Proposals for compulsory insurance provide for payment of practitioners under one or all of three methods: (a) fee for service, (b) per capita, or (c) salary. Use of the fee-for-service device represents the minimum degree of socialization, but it is administratively difficult. Administrative difficulties would probably result in the adoption of the per capita system which represents a higher degree of socialization or even in the salary system which represents practically complete socialization. It seems questionable whether a country which once embarks on compulsory insurance can turn back but must attempt to remedy defects by more complete government control and administration.

In view of the conclusions reached, it is recommended, first, that the national government would be wise to leave to the individual states the question of whether compulsory health insurance is to be adopted or whether the provision of professional services is to be left in the realm of free enterprise. It is considered highly improbable that experimentation with a variety of plans would ultimately lead to the development of a single pattern applicable to all sections of the country.

The second recommendation is that for the present the national government and many of the state governments may well devote their resources and energies to (a) research and development in the fields of public health, (b) health education at the school level, (c) teaching of preventive medicine, (d) assisting in the acquisition of physical facilities and training of personnel, and (e) providing systemic care for the indigent and the medically indigent.

The third and final recommendation suggests the proper place of government in educating the public with regard to medical care. It states that from the standpoint of public relations, governments may well be advised to leave adult educational campaigns for the control and prevention of disease to the national, state and local voluntary organizations which have been able to enlist the active cooperation of leading laymen in most sections of the country. Good health is not exclusively a matter of medical care. It hinges also, as is pointed out in the Report, on such other causative factors as food, shelter, vice and crime, transportation, and industry; too, its maintenance depends upon the intelligence, interest and cooperation of individuals, families and local communities.

A VOICE IN THE WILDERNESS PREPAYMENT MEDICINE WHAT LIES AHEAD?

Paul R. Hawley, M.D., Chief Executive Officer of the Blue Cross—Blue Chield Commission, can become brilliantly articulate. This he proved recently in dramatic fashion by means of a speech delivered before a conference of state medical association officers in Chicago.

Is his the voice of a prophet in the wilderness? Are the leaders of organized medicine in the United States today "Oh Lost?"

You be the judge. There follows an abstract of Dr. Hawley's thought-provoking address:

The dangers that threaten the free practice of medicine in this country are fast becoming critical. Still we refuse to unite in decisive action to meet them. We waste precious time in quarreling among ourselves over petty questions of local sovereignty. We amuse ourselves by setting up fantastic straw men and dissipate our energies in knocking them down, while our enemies unite against us in one national effort. We have thus far done no more than fight a series of rear guard actions with small uncoordinated groups. I know of no more certain road to disastrous defeat.

Our national leaders seem blind to the social changes that are taking place. It is impossible to halt a movement by merely refusing to recog-

nize its existence; and the movement toward extending the benefits of adequate medical care to all of our citizens has already gained too much momentum to be halted by any means.

The last hope of American medicine lies in abandoning our present position in the rear of the column and in establishing ourselves firmly in the forefront where we can guide and direct the movement into paths that are the best for our people as well as best for our profession.

I emphasize that the welfare of our people must be given at least as much consideration as the welfare of the health professions. Too many physicians regard medical care as their exclusive prerogative. We must recognize that the consumer of medical care also has a great stake in it. If any doubt has existed as to this, it should have been dispelled by the National Health Assembly, held in Washington early in May.

I shall offer no defense of the motives that prompted the organization of that health assembly. They may have been, as has been charged, largely political. But however impure the motives, only a very stupid person could have listened to the discussions and come away unimpressed both by the strength and by the determination of the groups committed to an effective program for prepayment of medical care. A resolution to the effect that only a compulsory government insurance plan could satisfy the criteria necessary for an effective plan was proposed and vigorously supported.

The array of strength behind that resolution should convince even the die-hard tories in the health professions that the threat of nationalization of medical care in this country is real, is acute, and soon will be—if it is not already—sufficiently great to precipitate action by the Congress.

The representatives of the people are swayed by the numbers of voters rather than by principles. Even discounting the smaller and more radical groups demanding national health insurance there remain the A. F. of L., the C. I. O., the National Women's Trade League, the United Mine Workers, and the Association for the Advancement of Colored People — all demanding health insurance. These represent a lot of votes.

What, then, will be the future of the voluntary prepayment plans for medical care? Those demanding national health insurance were generous enough to state that the voluntary plans should continue in operation after the inauguration of national health insurance. This, of course, was but a courteous gesture, since it would be impossible for voluntary plans to compete with a government plan since the latter would be supported at least one third by tax money.

Since it is impossible for voluntary plans to survive if and when national compulsory health insurance comes, we are going to have one or the other type of prepayment health insurance—not both.

National compulsory health insurance legislation cannot be prevented by political manipulation. It is my considered opinion that, if left to popular vote, the legislation might pass today.

But this disastrous legislation can be prevented if the voluntary plans meet every reasonable demand for health insurance. The medical care section of the National Health Assembly adopted unanimously seven criteria for measuring the effectiveness of prepayment plans, the first of which is: "The extent to which a prepayment plan makes available to those it serves the whole range of scientific medicine for prevention of disease and for treatment of all types of illness or injury."

To meet this criterion, voluntary plans must be in a position to offer as comprehensive coverage as the public demands, regardless of cost. Since different types of coverage are needed, prepayment plans will have to offer more than one type of contract. We must always, of course, offer a contract that is within the economic reach of the low income groups, but large union groups are demanding a much more comprehensive service. Moreover, they are willing and able to pay for it. We must be in a position to offer them a contract that meets their requirements. Otherwise we shall not only be forced out of business; we shall also have compulsory government health insurance as a reality instead of a threat.

It is easy to arrange a separate fee schedule for each type of contract. For the higher income groups, the fees should be higher and should correspond to the fees normally charged such groups. The wealthier groups expect that.

The next point of the greatest importance is that these large groups will not be satisfied with anything short of uniform coverage for their members, regardless of their place of residence. They simply will not deal with fifty-one separate Blue Shield plans.

Already the United Mine Workers, with 400,000 members, have a 10 cent per ton levy solely for health and welfare. Another

union with more than a million members has already appointed a medical advisory council to prepare a prepaid health program for its members, which also is to be paid for by a 10 cent per hour raise in pay.

Is organized medicine guiding and directing these programs? It is not! I happen to know some of the members of the medical advisory council of this gigantic union. They are openly committed to government compulsory health insurance.

Why was not organized medicine approached for advice and counsel in the establishment of these huge programs? I'll let you answer that question. But doesn't it shock you, doesn't it give you a feeling of insecurity, that the leadership of these great movements, which will exert the most profound effect upon medical practice in this country, has slipped from the grasp of organized medicine?

I can tell you that it disturbs me deeply. I am convinced that the cause is lost unless you take prompt and effective action to regain control of medical practice in this country. I say "regain" because I am afraid you have already lost it, whether you realize it or not.

Some weeks ago, I had a conference with one of the most powerful labor leaders in the United States, who has already started this movement for a prepaid medical care program in two of his largest unions. I am violating no confidence when I tell you that he exhibited a strong bias against the attitude of organized medicine. His closest welfare advisers made it clear to me that they would deal with the voluntary, nonprofit prepayment medical care plans only if these plans met their requirements to a reasonable degree. They set forth a few principles upon which they would not compromise, the two most important of which were uniform coverage for all their members and a single contract regardless of the number of individual medical care plans involved.

These requirements can be met easily, but not so long as our vision is limited by the boundaries of the small areas in which we live and practice medicine. The problem is one of national scope. Only a National Service Agency, controlled by all the participating Blue Shield plans, can possibly meet this urgent need.

As a physician who is intensely interested in the future of medicine in this country, I cannot see the slightest danger in merging the individual local Blue Shield plans into one effective unit. Each local Blue Shield plan would preserve its present degree of autonomy. The national agency would be one that served all the plans, rather than one that controlled all the plans.

And don't forget one thing: It is either some such arrangement or be forced out of business. If we are not going to be in a position to serve these new millions of consumers of medical care, we had better announce that fact right now and liquidate our Blue Shield plans. Sudden death is much preferable to a lingering, painful death; and slow death for us is certain, unless we get in step with the rest of the country.

I mentioned earlier that straw men were being set up. Perhaps the largest of these straw men is that this is just a scheme for Blue Cross to gain control of medical practice. This is not only the largest of the straw men; it is the most fragile.

I beg of you not to be misled by any such vicious propaganda. As long as I remain in this position, I shall defend medical practice just as zealously as I uphold the principles of Blue Cross. If there were any real areas of conflict between these two organizations, I would certainly discover them at once; and I can find none.

But my heart grows heavy as I see the indifference of many physicians to the threat to freedom in medicine that is becoming more menacing each day; and as I encounter the petty, selfish greed of a few physicians who had rather see the entire structure of American medicine wrecked than to concede one small personal advantage in the general interest.

If we get socialized medicine in this country, it will be organized medicine, and only organized medicine, that has brought this curse upon us. We, as physicians, will have only ourselves to blame.

The demand for more comprehensive medical care, and for an effective means of budgeting its costs, has grown, within ten years, from a whisper to a roar. Our people will not be denied much longer. If the medical profession does not at once assume the leadership, if it does not at once cease its double talk and double dealing with the voluntary nonprofit prepayment plans, we are going to have compulsory government health insurance in this country within three to five years.

Don't be lulled into a sense of security by such able studies on socialized medicine as have been made by the Brookings Institution, the National Industrial Conference Board, and other capable agencies. Of course, every thinking person

is convinced that socialized medicine would be a mistake—a costly mistake both in money and in health. But this issue will not be decided by wisdom. It will be decided by emotion.

Like President Coolidge's preacher, who was "agin sin," everyone is against sickness and death. Only a small minority of our people can understand the dangers of socialized medicine—all they know is that they want everyone to have good medical care, and they are not capable of choosing between the various ways in which medical care can be better distributed. Only a "fait accompli" will convince them—and we have only a short time to show them an accomplished fact.

It is useless for the medical profession to undertake the education of our people to the dangers of socialized medicine. Our public relations have been so miserable in the past few years that a majority of our people suspect us of having only a selfish, personal interest in this question. I honestly believe that the medical profession does more harm than good when it attempts to decry socialized medicine. Our motives are too suspect.

Don't be misled by such absurdities as the assurance that the government cannot make you practice medicine if you do not want to. See what has happened in England. The members of the British Medical Association voted at first to have nothing to do with government medicine. Eighty per cent pledged themselves to remain outside the government plan. But, as the deadline for participation approached, British physicians, by a small majority, voted to accept the government plan.

How long could you hold out in a strike against the government? How many of you could stick it a year with no income? How many of you would stick it if you saw a minority group collecting all the gravy? How many of you would be willing to forsake medicine and embark upon another career?

Don't let anyone fool you! If government medicine comes, 90 per cent of you will be forced by circumstances to accept it, no matter how bitter a pill it will be for you to swallow. So, the only way to prevent this tragedy is to stop it before it arrives. There is little you can do about it after it comes.

The medical profession can prevent this tragedy, but only by positive action that will meet the reasonable demands of the large groups cited. Consistently negative action has brought us to this critical juncture, and has played directly into the hands of enemies of free medicine. Time is running against us. We can not longer delay. If expansion of the Blue Shield movement is not encouraged, the death knell of free medicine in this country will have been sounded.

Thus spoke Paul R. Hawley.

The issue is clear. The Journal has pointed out in the past, editorially, that the question is not whether we want socialized medicine, but, rather, what form of socialized medicine do we want? Do we want the voluntary, nonprofit, participating plan or the bureaucratic, undemocratic, compulsory government form?

As Dr. Hawley has stated, the issue probably will be decided not by wisdom, but by emotion. It is paramount that we offer the masses wider coverage and better financial protection from sickness—that we have a way and that we—not the politicians—show that way. That is the cue for our leaders.

Leaders of organized medicine have made mistakes in the past in regard to this problem, it is true, but theirs were mistakes of the mind and not of the heart. It is to be hoped that today most of them realize those mistakes. Fortunately, those physicians referred to by Dr. Hawley, who show selfish greed and who would rather see the entire structure of American medicine wrecked than to concede one small personal advantage in the general interest, are in the small minority. Likewise, those physicians who resent criticism and who will take exception to parts of Dr. Hawley's frank appraisal of this vital problem probably also will be in the small minority.

We need to look forward now, not backward. We need an outstanding leader who has knowledge of the problems involved, and vision with which to solve them. Perhaps Dr. Hawley, with his clear voice and with the courage and forthrightness which he has shown, will become that leader.

Webster Merritt

PROPER IDENTIFICATION OF BLUE SHIELD CLAIMS URGED

Because improper claims, which cannot be honored, are being received in the home office of the Blue Shield Plan, participating physicians are particularly cautioned to substantiate their patients' eligibility for benefits. Claims are being submitted for services rendered patients having

Blue Cross protection only and naturally cannot be paid by Blue Shield. It is of utmost importance that proper identification for Blue Shield services be established by patients at the time financial arrangements are made.

The Blue Shield and the Blue Cross are two separate organizations with separate and individual enrolment in each. Many persons, having Blue Cross membership only, are under the impression that such membership entitles them to services under the Blue Shield Plan and consequently present their Blue Cross identification cards to physicians when making arrangements for services. The confusion arises when physicians honor Blue Cross identification cards for Blue Shield services. The identification cards of these two plans can easily be distinguished by their respective Blue Shield and Blue Cross emblems.

Physicians and their secretaries are asked to check identification cards carefully to determine if patients are eligible for Blue Shield benefits.

There seems also to be a misunderstanding by some physicians on the amounts allowed for anesthesia, x-ray and pathology. These services are covered under Blue Shield contract, but unlike the surgical procedures listed in the Fee Schedule are carried as indemnity, rather than a service benefit. Income limitations of Blue Shield members need not have any bearing on the fees charged for the above mentioned services. The physician may make his regular charge to the Blue Shield member in the low income bracket and apply the amount allowed for these services as a credit against his regular charge.

Indications are that the new Blue Shield Fee Schedule, effective September 1, is being received favorably. Claims are being processed promptly with little or no delay. Participating physicians are urged to familiarize themselves with the operation of the Fee Schedule and to make their service reports accordingly. Especial note should be made of the "I.C." (Individual Consideration) items listed in the Fee Schedule. Service reports should include a detailed description of "I.C." claims. The code number system, introduced in the new Fee Schedule, facilitates the prompt handling of claims.

Objections or recommended changes to the new Fee Schedule will be carefully considered. Blue Shield—the doctors' own plan—has as its objective: adequate medical care for free people by free doctors.

A. M. A. INTERIM SESSION ST. LOUIS, NOV. 30—Dec. 3

The second annual Interim Meeting of the American Medical Association, convening in St. Louis on the last day of this month, holds particular interest for Florida physicians in that it offers a foretaste of things to come. The 1949 Interim Session is scheduled to meet in Tampa.

The St. Louis session is planned to be especially valuable to the general practitioner. Lecture meetings will feature conditions most often seen in daily practice. The subjects chosen for discussion include diabetes, heart disease, cancer, poliomyelitis, obstetrics, pediatrics, dermatology, genitourinary conditions, hypertension, anesthesia, tuberculosis, jaundice, laboratory diagnosis, x-ray diagnosis, and physical medicine as applied to the treatment of arthritis.

Correlated with the lecture meetings will be a wide variety of clinical conferences. In these conferences diagnosis and treatment will be stressed by medical leaders from all sections of the country.

The General Scientific Meetings in the St. Louis Opera House twice daily, an elaborate scientific exhibit with at least six demonstration units planned for each half day, and technical exhibits by more than one hundred leading firms will offer special attraction. At night, distinguished speakers will be featured, the award of the general practitioner medal will be made, and entertainment will be provided by stars of the amusement world.

On the eve of the Interim Meeting, Saturday, November 27, the first national Public Relations Conference will be held at the Statler Hotel under the sponsorship of the American Medical Association.

All reservations must be received before November 9. They must be cleared through the Chairman, Subcommittee on Hotels, American Medical Association, Hotel Reservation Bureau, 1420 Syndicate Trust Building, St. Louis 1, Mo.

NATIONAL DIABETES WEEK DECEMBER 6—12

An appeal to the practicing physicians of this country to take the lead in the fight against diabetes is currently being made by the Committee on Diabetes Detection of the American Diabetes Association, and National Diabetes Week beginning Dec. 6, 1948 is being sponsored. Through

their district and state medical societies and through local diabetes associations, physicians are urged to launch a full scale attack on this disease, which ranks eighth among the leading causes of death.

It is pointed out that the mortality rate for diabetics first seen when a complication has occurred is three times the rate for those first seen earlier and before impairments have developed. Too, surveys indicate that there are at least a million persons in the United States and Canada suffering from diabetes in whom the disease is undiagnosed. The discovery and treatment of diabetes mellitus at an early stage are therefore of major importance and have a particular claim upon the attention of all practicing physicians.

With the future for the diabetic patient under modern treatment actually brighter and more hopeful today than ever before, the committee urges active participation of medical societies in the present movement at both state and county levels through their committees on diabetes, on postgraduate instruction and on public relations, and through women's organizations, especially the women's auxiliaries of the medical societies. A growing number of local diabetes associations are accepting the challenge. They are being assisted by the American Diabetes Association in attaining such objectives as making available more graduate courses in diabetes for physicians, providing better laboratory services and helping with instructions for patients.

DIAMOND JUBILEE OF NURSING NOVEMBER 14—20

The Diamond Jubilee of Nursing, Nursing Progress Week and Linda Richards Day will be celebrated on a nationwide scale during the week of November 14-20. A committee of seventy leaders in public life, including President Truman, ex-president Herbert Hoover and Senator Arthur H. Vandenberg, will cooperate with the American Nurses' Association in sponsoring the occasion. A coast-to-coast program of activities will highlight the history and progress of nursing to the present day and pay tribute to the 320,000 registered professional nurses of America.

The Jubilee is expected to focus public attention on the extension and improvement of nursing service through the improvement of schools of nursing, economic security for all nurses, adequate licensure laws and more effective counseling and placement of both prospective students and graduate nurses. A most important objective is to stimulate the recruitment of 40,000 additional students for approved schools of nursing, desperately needed if professional nursing needs are to be met.

It was in 1873 that Linda Richards, the Florence Nightingale of America, was graduated from the New England Hospital for Women and Children in Boston as America's first nurse specifically educated for a professional career. The year of her graduation saw the establishment of the first three American schools of nursing based on the Florence Nightingale system. This great pioneer, whose foresight, courage and energy made modern professional nursing possible, founded eleven schools of nursing in this country and one in Japan, where she taught for five years. She is also credited with the organization and direction of the earliest schools of nursing in hospitals for the mentally ill.

In the three quarters of a century of its existence modern trained nursing has moved from height to height until today the nurse is an indispensable part of American life. In the words of Pearl McIver, the president of the American Nurses' Association, "Her skill, courage, intelligence, loyalty, tenderness, self sacrifice and strength of character have served the nation in peace and war. The Diamond Jubilee will remind us that wherever nature and man assail life, the nurse, eternal aide and colleague of the physician, is there to save it."

STATE BOARD OF HEALTH

Dr. Joseph M. Bistowish, Jr., assistant director of the Alachua County Health Department, has been granted a leave of absence to take a postgraduate course in public health at the Johns Hopkins University.

Dr. James B. Hall, director of the Division of Cancer Control, Florida State Board of Health, has been given a leave of absence to take a nine months' course in public health at the University of California.

Dr. Charles O. Parker, Jr., of Waycross, Ga., has been appointed health officer of the Lake County Health Department with headquarters at Tavares. He succeeds Dr. R. J. Dalton, who resigned.

Dr. Edward C. Love, Jr., of Quincy has been appointed health officer of the unit composed of the Gadsden, Liberty and Calhoun County Health Departments. Headquarters are at Quincy.

MEDICAL OFFICERS RETURNED

Dr. Claude Anderson, who entered military service on July 15, 1941, received his discharge on June 30, 1947. His address is 302 Blount Building, Fort Lauderdale. He held the rank of Commander.

Dr. Royston Miller, who entered military service on April 1, 1942, received his discharge on May 28, 1946. His address is 502 East Colonial Drive, Orlando. He held the rank of Lieutenant Commander.

Dr. Bernard L. Rhodes, Jr., who entered military service on Dec. 18, 1943, received his discharge on May 1, 1947. His address is University Infirmary, Gainesville. He held the rank of Lieutenant in the United States Navy.

Dr. Eugene G. Peek, Jr., who entered military service on July 7, 1946, received his discharge on July 7, 1948. His address is Commercial Bank Building, Ocala. He held the rank of Captain.

Dr. George H. Massey, who entered military service in 1946, received his discharge on Aug. 25, 1948. His address is Quincy. He held the rank of Captain in the Army. Dr. Massey returned recently from Berlin, Germany, where he served for two and one-half years. He is a son of Dr. Wm. M. Massey.

SITUATION WANTED: Otolaryngology and ophthalmology association with group or with private physician by Board eligible physician; graduate of Grade A southern medical school; physically fit; 40 years of age. Write 69-19, P. O. Box 1018, Jacksonville, Fla.

STATE NEWS ITEMS

For the past several months plans have been formulating in connection wth the Association's Seventy-Fifth Annual Convention to be held next April at the Belleview-Biltmore Hotel in Belleair. There is every indication that this will be an outstanding occasion.

The assembly room for the scientific assemblies will be cool and is equipped for darkening when a projecting lantern is used. Dr. Chas. J. Collins, chairman of the Scientific Work Committee, urges that every member who wishes to read a paper at the scientific assembly should make application not later than during the month of November. His address is 1503 Kuhl Avenue, Orlando. The applicant should submit a copy of his paper or a fifty-word synopsis.

The specialty groups, who meet on the Sunday preceding the opening of the state meeting, will find their assembly rooms unusually pleasant. It is anticipated that all specialty groups will be able to meet on the hotel grounds.

On September 21, Dr. Douglas D. Martin, president of the Hillsborough County Medical Society, appointed Dr. David R. Murphey, Jr., as Cabinet Chairman. Dr. Francis H. Langley, president-elect of the Pinellas County Medical Society, appointed Dr. M. Eldridge Black as Cabinet Chairman. At an evening meeting on the same day Drs. M. Eldridge Black, David R. Murphey, Jr., Herschel G. Cole, Francis H. Langley, Stewart G. Thompson and Mr. Ernest R. Gibson met to discuss plans for local society committees. President Martin was out of the state and Dr. Cole, secretary of the Hillsborough County Medical Society, sat in as his proxy.

Since this is a joint invitation from the two societies, it was decided to have six local committees from each as a matter of convenience. There are twelve local committees, six chosen by each Cabinet Chairman to represent his society.

Dr. William D. Wells of Fort Lauderdale recently joined the Broward County Medical Society and the Florida Medical Association. Dr. Wells will limit his practice to urology.

On September 27, Dr. Irby H. Black, secretary of the Madison-Suwannee County Medical Society and Councilor of District 2, called a meeting of doctors of both counties to discuss the advisability of having two separate county medical societies. Twelve doctors were present. Dr. Stewart Thompson attended in an advisory capacity at the request of Dr. Black. A number of the doctors present are not now members of the county medical society so the matter is to be held in abeyance until a sufficient number of doctors have joined to make separate county medical societies advisable.

Dr. Jess V. Cohn, formerly of Miami Beach, has accepted a position as Assistant Superintendent of Central State Hospital in Indianapolis, Ind. He also will hold a teaching post at the College of Medicine of the University of Indiana. Dr. Cohn has been a member of the Florida Medical Association for the past twelve years.

Dr. Arnold S. Anderson of St. Petersburg won the silver pitcher of the Internal Medicine Section at the American Medical Golfing Association event which was held at Olympia Fields during the annual meeting of the American Medical Association in Chicago.

Dr. Harrison G. Palmer has returned to St. Petersburg after visiting hospitals and clinics throughout the Northwest. While on his trip, which included the A. M. A. convention, Dr. Palmer motored to Seattle, Portland, Salt Lake City, Denver and the Yellowstone National Park.

Dr. Wallace H. Mitchell of Key West has opened offices for the practice of general medicine there after completing an internship at the Jackson Memorial Hospital in Miami.

Dr. Ralph N. Greene, Jr., recently announced the opening of offices at 1024 LaSalle Street, South Jacksonville. Dr. Green will limit his practice to ophthalmology.

Dr. John P. Gifford of Vero Beach was the guest speaker at a meeting of the local Rotary Club in September. The subject of Dr. Gifford's address was "Modern Medicine."

Many physicians in the Greater Miami area attended a symposium on vascular diseases which was held at the Pratt Veterans Administration Hospital in Coral Gables on September 16. The program included the following papers which were presented by three Emory University professors and a Veterans Administration physician: "Radioactive Isotopes As Tracers in Peripheral Vascular Disturbances," Dr. Fred W. Cooper, Jr., assistant professor of surgery at Emory; "Contrast Visualization of the Vascular System," Dr. David F. James, chief of medical service at Emory University Hospital; "Surgical Treatment of Thrombo-Embolic Diseases," Dr. Ira A. Ferguson, associate professor of surgery at Emory; "Low Protein Diet in Treatment of Congestive Heart Failure," Dr. Walter M. Bartlett, chief of medical division, Veterans Administration, Atlanta.

BIRTHS, MARRIAGES AND DEATHS

BIRTHS

Dr. and Mrs. Edward S. Miller, St. Augustine, announce the birth of a son, John Humphrey, on Aug. 25, 1948.

MARRIAGES

Dr. Donald H. Anderson of Port St. Joe and Miss Mary P. Clark of Roanoke Rapids, N. C., were married on Sept. 4, 1948, in Panama City, Fla.

DEATHS—MEMBERS

Dr. Geo. C. Overstreet, Lakeland	Sept. 14, 1948
Dr. James H. Pittman, West Palm Beach	Sept. 24, 1948
Dr. Francis B. Enneis, Jacksonville	Sept. 30, 1948

DEATHS—OTHER DOCTORS

Dr. William A. Brewer, Cowan, Tenn.	May 24, 1948
Dr. Edward P. Brewer, Miami	May 10, 1948
Dr. Heywood H. Hopkins, Rochester, N. Y.	May 13, 1948

FLORIDA ACADEMY OF PUBLIC MEDICINE
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Editor's Note:

The purpose of the Academy is to promote a program of public relations under the supervision of the Florida Medical Association. At present all officers and members of the Academy are also members of the Florida Medical Association.

NEWSPAPER EDITOR'S VIEWS ON COMPULSORY HEALTH INSURANCE

Numerous editorials on some aspects of socialized medicine appear in the newspapers of the state from time to time. Many of these are favorable. Even when highly critical of the medical profession, the suggestions are generally of a constructive nature. However, some criticisms are unjust and have implications not warranted by the facts. We believe it to be the duty of the Academy to answer such newspaper editorials. The following editorial appeared in the September 9 issue of the Indian River News. It is reproduced here in full together with the Academy's reply.

"HIPPOCRATIC . . . . OR ELSE"
Dale Wimbrow

The doctors of this country are worried. Things are brewing that point to another facet of socialization, namely (to quote "Li'l Abner") socialized medicine.

Personally and privately, we hate the word socialism almost to the point of nausea. But there is always another side to a question, and some more grass on the other side of the fence. When you read statistics like the following you've got to squint one eye and start cogitating: "Nearly a half million people in this country die each year because they can't pay their doctor."

Now, if a man dies because he's been careless, or reckless, or foolish, or short sighted, or greedy, or crooked, or dishonest, or gluttonous, or intemperate, or just plain mean (as many, of course, do) that's one thing. But if a man or woman is just bitten by some obscure little microbe they can't see, and they die; because they can't scrape up sufficient mazola to pay the medical freight . . . that's something else.

It is decidedly something else. And it shouldn't be . . . and it won't be much longer. And the Doctors might as well get in line with modern thinking and stop militating against the bugaboo; "Socialized medicine."

If it takes socialized medicine to stop this extravagant waste of human life; then "Doc" . . . it's gonna be socialized medicine; and you can lay to that, and we can tell you some of the reasons. Lack of ability to pay for medical services is killing not only "people" . . . it's killing off the breed which was suckled at the breast of independence, and raised on the doctrine of individual initiative, and enterprise. Now, just in case we didn't make that plain, we mean the breed who are too proud to accept charity; or to ask for a handout. Lack of ability to pay is a common affliction of most of us these days; because, after the major part of our earnings goes to the butcher, baker, and gadget maker . . . we just can't afford to get sick; and if we do . . . well, you can finish that sentence in your own language.

Now the doctors have their side of it. We have seen, in our nearly three score years, three of our family doctors kill themselves with overwork. We saw "Doc" Holland wear out four horses, beginning back in our boyhood with old "Prince," and working up to a model T "Lizzie."

"Doc" took us on his maiden voyage in that "Lizzie." He had just learned how to drive; but "Minnie," his last hoss, was still fresh in his mind. When we finally came to an unexpected water hole in the road, "Doc" rared back on the wheel and hollered, "Whoa! Minnie! Whoa!" But "Lizzie" wasn't "Minnie," and didn't know that language anyhow; so we wound up over the hubs in the hole; and had to be towed out by Ike Lewis' team across the branch. Ike's daughter was busy having a grandson for him; but she waited 'till "Doc" got there, and took off his shoes.

"Doc" had one price. It was a dollar. That went for day and night. If a kid had a green apple bellyache "Doc" got up in the middle of the night and gave him some bicarb or peppermint extract, or an emetic, or something. He even got up to patch up a quarrel between two newlyweds.

"Doc" seldom got paid, never slept, and died of Angina . . . "Doctor's disease" they used to call it. "Doc" never asked if a man had dough enough to pay him for a call. He "Called" first; and found out whether there was any dough later. He lived a full life while he lived. Raised a nice family of girls and boys, and sang tenor in the church choir . . . even if he had to break off on a high note to go put a poultice on a case of poison ivy. "Doc" did his duty as he saw it . . . Everybody loved him . . . most of 'em paid him when they could . . . and he went to Heaven just as sure as there's a Heaven.

He went to college at great expense, and even in those days a day laborer made as much clear money as "Doc." He had a notion that a doctor was a sort of a public servant like a preacher, and a school teacher put down on this vale o' tears to help ease the miseries of his fellowman. It was a crackpot notion, or was it?

All the Doctors were mostly of that "notion" in those days. Few of them were rich . . . or tried to be . . . or ever expected to me. The "Ol' Doc

Pills" of those days seldom charged top money for standard specifics. There were a few pink-colored flour pellets dispensed to neurotic characters or those perfectly healthy hypochondriacs who insisted upon being invalids. But in the main "Doc" sold only a little medicine . . . and at modest prices. His pills sold at what the pharmaceutical supply house charged him. "Doc" was "old Fashioned," maybe, according to modern standards; but he was the "old Fashioned" kind that Heaven is full of; *and* they didn't talk about "socialized medicine" in those days.

We don't know just what direction public thinking is going to take. We have a great deal of sympathy for the doctors. We know that their knowledge, and skill is acquired at great pains, and at great expense. We know that hunger can chew at their vitals the same as though they hefted a pick axe, or a plow handle, or a plumber's wrench. They are human.

Hippocrates was human too, but he ranks up there with the saints of legend. A doctor to most of us is a haven of refuge . . . a calm harbor in a storm. He's the last resort of a private layman driven to desperation by strange, and mysterious circumstances. When he dons the Hippocratic robe he wears a garment that will *always* be too big for any man. We have a great reverence for a doctor.

But we can't have a half million people dying because they are too proud to admit that they can't pay for the privilege of sitting under a physician's ministering hands. The ministering hands have now become too expensive. The price of a physician's services are just too steep for the average man's family today; unless, the family is on the relief list and taken care of by the county or a charitable organization.

At this time it might be just as well to point out that the very taxpayer who supports the relief rolls, and makes free medical care possible for those unable to stand the expense; that same taxpayer can't afford to pay the price to keep his own family in good health. So what? They either die from neglect, or the taxpayer puts a mortgage on his home. So what again? The guy who wants to pay . . . and can't afford it . . . dies off. The guy who can't, or won't pay is nurtured. The thing is lopsided, and some adjustment is going to be made sooner or later.

We believe a laborer is "worthy of his hire." The doctors are "worth" anything they can get; but it is a question of what the traffic can stand that confronts the average man today. The price of medical care has simply reached the saturation point.

No Doctor, who calls himself a Doctor, has a right to refuse a "call" regardless of whether he *ever* gets paid. That's "cold turkey;" but it is an implied compliment. A doctor is not just another guy with a handsaw, or a trowel, or a plumb-bob. Those jobs can be done by a million other men today . . . or next week. A carpenter's job can wait . . . a human life can't.

Every time a Doctor refuses a call, for any reason whatsoever, he moves "socialized medicine" ahead by six months. Lack of money should condemn no man or woman to a preventable death. Nor should it be necessary for medical care of the indigent to be administered on the basis of charity. There is a solution to the problem and from where we sit we would say that the A. M. A. has the greatest interest at stake.

The great American Medical Association of doctors *can* work the thing out . . . for God help 'em . . . and us . . . if the politicians have to do it.

FLORIDA ACADEMY OF PUBLIC MEDICINE

404 Florida Theatre Building
Jacksonville 2, Florida
September 24, 1948

Mr. Dale Wimbrow, Editor and Publisher
Indian River News
Sebastian, Florida

Dear Editor:

You editorial "Hippocratic . . . Or Else" in the September 9 issue of the News is thought-provoking. Your desire to have adequate medical care for everyone is highly laudable. With that the medical profession will readily agree. We are unable to concur completely with your analysis of the situation.

In the few paragraphs of your editorial you have introduced many angles to the problem of medical care. You have mentioned issues concerning which volumes already have been written, on both sides of the question. No one editorial can possibly do justice to the over-all problem. It leaves too many things unexplained and makes implications which may or may not be justified.

You have issued a friendly warning to the medical profession, together with a challenge. You believe that the combined efforts of national, state, and local medical societies can meet this challenge, but that the time is short and action must not be delayed. The medical profession appreciates and shares your confidence but, Mr. Editor, we can't do it alone. The press will have to help.

You seem greatly concerned over the failure of physicians to follow the oath of Hippocrates to the letter. Many of us will have to plead guilty, since so few doctors are perfect. I do think, however, that the majority of physicians make an honest effort to approach this state of perfection. I shouldn't be surprised but that we come just about as close as do the members of other professions in adhering to their codes of ethics, not excepting newspapermen.

I should like the privilege of making a few observations concerning certain statements and implications contained in your editorial which do not appear to be entirely clear. I should like to carry your own line of reasoning just a bit farther.

You state that this editorial was stimulated by reading that "Nearly half a million people in

this country die each year because they can't afford to pay their doctor." This gives cause to wonder how your informant arrives at that particular figure with the implication that inability to pay, and that alone, is the reason they die; that if in some manner their doctors get paid they unquestionably will live, nothing else can kill them; that if the money were made available to them there can be no question but that it would go to their doctors, or if the bill had already been paid, in some manner, all would take full advantage of their opportunities, without exception.

Your picture of the "Doc" of your boyhood days evokes fond memories in many of us. Of course I agree with you on this and, as a physician can visualize still other aspects about which the public never knows. Old "Doc" deserves all the credit he can get, although it comes posthumously.

Without wishing to take a thing away from the old time practitioner, I should like to add a few more ideas just to balance the picture. Your "Doc" never refused to get up in the middle of the night to administer relief for a bellyache, which probably started long before the doctor went to bed. Is it not possible that there have been times that attention to bellyaches forced the doctor to delay reaching a seriously ill patient, just a little too long?

I wonder how many patients received less than the best your old-time doctor was able to give simply because he was too tired to think clearly. Ask yourself what kind of newspaper you are likely to publish if required to go night after night with interrupted sleep, sometimes none at all.

Your "Doc" died of a heart ailment brought on by overwork and improper rest. Surely there must have been many other persons he could have treated, much misery he could have lessened and numerous lives he might have saved had he not died so soon.

It doesn't seem quite fair to ask for the return of the old-fashioned doctor with his "Lizzie" and his horse and buggy equipment. He would be a pretty lonesome chap. Gone would be the old-fashioned laborer he knew. The one who finished the job regardless of when the whistle blew. The worker who knew nothing about overtime, portal-to-portal pay, collective bargaining and other like terms. Memory carries me back to some newsaper offices of long ago. I can't believe that your modern-looking paper comes from that sort of plant, nor that it is the work of that type editor.

Naturally the medical profession does not desire federal control and supervision of medical care. We know that the profession would be hurt much less than the public, who will be paying the bill. I should say paying the bills, for after all, most citizens who are able to pay for private medical care will do so, even though they will be paying taxes for political medicine as well. If the proponents of so-called federal health insurance could actually deliver any reasonable proportion of what they promise the situation would not be quite so frightening.

You know you don't want political control of medicine. You say so. If it happens to us it will also happen to you eventually. Gone will be the free press. You know as well as I that Franklin Roosevelt and "Red" Pepper and all of their ilk were, and for the most part still are, only interested in socialized medicine for the political benefit that would accrue to them.

You infer that the medical profession has as yet done nothing to correct the situation. Do you think that is quite fair? Today there are voluntary prepay hospital and medical care plans. These are known as Blue Cross and Blue Shield. These may not be the complete answer but at least they are a start. They are expanding rapidly and in so doing the extent of coverage is being increased. The better these plans are known the more likely they are to reach everyone. The press can be a big help. Frankly we have been disappointed at the assistance coming from the newspapers. It seems not quite cricket to criticize us for failing our job and not giving your full cooperation to help accomplish the mutually desired objective.

I liked your editorial in spite of all the grumblings. I'm glad you didn't pull your punches. I wish more editors would speak out their views. Thanks for bearing with me in this lengthy reply.

Sincerely yours,
Shaler Richardson, M.D.
Secretary

The Academy will appreciate receiving any press clippings of news stories and editorials containing criticisms of the medical profession. The Academy then can present to such editors information which will better explain the position of the medical profession, and show the fallacies of many arguments advocating a change in medical practice in this country.

COMPONENT SOCIETY NOTES

BAY

Members of the Bay County Medical Society were addressed in September by John Ferrell, nuclear physicist from the United States Navy Mine Countermeasures Station. The speaker discussed the fundamentals of atom-smashing and its relation to medicine.

Society members present include Drs. J. Powell Adams, Chas. T. Barton, Lemuel F. Coxe, Jr., Charles H. Daffin, James E. Kerr, M. J. Lingo, Amsie H. Lisenby, Martle F. Parker, William C. Roberts, C. W. Shackelford and Russell T. Stewart. Dr. Jack Corbitt was a guest at the meeting.

DESOTO-HARDEE-HIGHLANDS-CHARLOTTE-GLADES

At the Sept. 14, 1948 meeting of the DeSoto-Hardee-Highlands-Charlotte-Glades County Medical Society, Dr. Harold Carron of Tampa spoke on "Anesthesia."

MADISON-SUWANNEE

Dr. John N. Sims of Toccoa, Ga., and Dr. J. Dillard Workman of Lake Worth have transferred their practices to Live Oak and have applied for admission to the Madison-Suwannee County Medical Society.

MONROE

The members of the Monroe County Medical Society met with the staff of the United States Naval Hospital, Key West, at the Officer's Club to hear a paper on "Heart Disease" by Dr. Franz H. Stewart of Miami.

PINELLAS

At a recent meeting of the Pinellas County Medical Society, the speakers were Drs. Claude B. Wright and Arnold S. Anderson. They were introduced by Dr. Francis H. Langley.

Dr. Wright spoke on "Placenta Praevia." His paper was discussed by Drs. Raymond H. Center, Woodrow B. Estes and Edward V. Pollard.

Dr. Anderson's paper was entitled "Report on Project A. M. A. 1948."

SEMINOLE

The regular meeting of the Seminole County Medical Society was held on September 15 with Dr. Harry Z. Silsby presiding. The topic of discussion following the dinner was community service.

FRANK LEROY HALL

Dr. Frank L. Hall of Sarasota died on July 14, 1948 at his summer home in Grand Isle, Vt. He was 50 years of age.

Dr. Hall was born in Westfield, N. J., and received his medical education at the Georgetown University School of Medicine in Washington, D. C., from which he was graduated in 1925. His internship was served at Gallinger Muncipal Hospital in Washington. He was licensed to practice medicine in Vermont in 1933 and in Florida in 1945. Dr. Hall had done postgraduate study at Johns Hopkins University and the McGill Medical School in Montreal, Canada.

At the time of his death, Dr. Hall was city health officer of Sarasota, a position which he also had held in previous years. He specialized in geriatrics. Dr. Hall was a member of the staffs of the Sarasota Hospital and of the Mary Fletcher and Bishop DeGoesbriand hospitals in Burlington, Vt.

He was a member of the Sarasota Medical Society, the Florida Medical Association and the American Medical Association.

Survivors include his widow, Mrs. Marion Hall, and two daughters, Blanche and Bunny.

GEORGE CLENON OVERSTREET

Dr. George C. Overstreet of Lakeland died of a cerebral hemorrhage on Sept. 14, 1948 in the Tampa Municipal Hospital. He had suffered the hemorrhage four days previously in a hotel in Tampa, where he had gone to consult a specialist under whose care he had been for some time. He was 55 years of age.

Dr. Overstreet was born on Aug. 4, 1893 in Baxley, Ga. He was graduated from Emory University School of Medicine in Atlanta in 1917 and in 1925 opened offices in Lakeland where he had practiced until the time of his death. Since 1939 Dr. Overstreet had been city health officer in Lakeland.

The surgeon was a member of the Polk County Medical Society, the Florida Medical Association, which he served in the capacities of councilor and committeeman, and the American Medical Association.

Locally, he was affiliated with the Masonic order and the Egypt Temple of the Shrine, Tampa. Dr. Overstreet was a member of the Methodist church.

Survivors include his widow, Mrs. Jimmie Barnes Overstreet; a daughter, Mrs. C. V. Nalley, Gainesville, Ga.; his mother, Mrs. Mazelle Overstreet, Baxley, Ga.; and two grandchildren.

JAMES WALKER SMITH

Dr. James W. Smith of Miami died on Aug. 14, 1948 in the Jackson Memorial Hospital. He was 79 years of age.

Dr. Smith was born in 1869 in Beetown, Wis. He received his medical degree in 1894 at the Northwestern University Medical School. In 1901 he went to the Philippine Islands, where he first engaged in military medical service, then in the United States Public Health Service, and eventually in private practice.

While in residence in the Philippines he served as chief surgeon of Bilibid Hospital in Manila and also was affiliated with St. Paul's, St. Luke's and Philippine General hospitals in Manila. At one time he was chief surgeon of Baguio Hospital in Baguio. Dr. Smith had conducted extensive research on beri-beri, Asiastic cholera and bubonic plague.

In 1925 Dr. Smith located in Miami, where he engaged in limited practice. His special skill in bone surgery was enhanced by postgraduate courses at the Royal College of Vienna, Austria. He also had done postgraduate study at the University of Chicago.

Dr. Smith was a member of the Dade County Medical Association, an honorary member of the Florida Medical Association and a fellow of the American Medical Association. He also was a member of the Manila Medical Society and a fellow of the American College of Surgeons.

He is survived by his widow, Mrs. May Smith of Miami.

FRANK LESLIE SNYDER

Dr. F. Leslie Snyder of Fort Lauderdale died on July 28, 1948 in the Good Samaritan Hospital in West Palm Beach. Dr. Snyder had suffered head injuries three days previously in an automobile accident near West Palm Beach. He was 37 years of age.

Dr. Snyder was born on Nov. 13, 1910 in Hamilton, Ohio. He received his medical degree from the Ohio State University College of Medicine in Columbus in 1935. Following graduation, he served as resident surgeon at Jackson Memorial Hosptal in Miami.

He was a staff member of the Hollywood Clinic for several years prior to World War II. He entered the United States Army, serving as flight surgeon in the Air Corps, and was separated from the service in 1946 with the rank of major. Since that time he had practiced medicine and surgery in Fort Lauderdale. He was a member of the staff of Broward General Hospital.

Dr. Snyder was a member of the Broward County Medical Society, having served as its secretary in 1946. He also was a member of the Florida Medical Association, the American Medical Association, the American College of Surgeons and the Southeastern Surgical Congress.

Survivors include his widow, Mrs. Marie Lackey Snyder; a daughter, Leslie; a son, Richard L.; his parents, Mr. and Mrs. F. L. Snyder of Hamilton, Ohio; and a sister, Miss Claire Snyder of Fort Lauderdale.

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ROLE OF AUXILIARY IN PUBLIC RELATIONS

The Public Relations Committee of the Woman's Auxiliary is proving in many ways to be of valuable assistance to the Association. More emphasis has been placed on a health education program. There are innumerable methods by which this can be accomplished.

It is the desire of the public relations chairman to have every doctor's wife an Auxiliary member and every Auxiliary member a public relations worker whether or not she may be on such a committee. Some may ask how this can be done. Some projects which have the approval of the Association in which the Auxiliary may help follow.

1. Watch the weekly, or semiweekly, newspapers for "Health Topics." This is an educational column released by the Florida Academy of Public Medicine as a public relations project of the Florida Medical Association. Advise the proper county medical society officer of the local publication of "Health Topics."

2. Listen for medical radio programs being sponsored by the local medical society and for network programs sponsored by the American Medical Association. Report these programs to the proper county medical society officer and urge friends to listen to them.

3. Cooperate with your local county medical society Speaker's Bureau in connection with

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From where I sit
by Joe Marsh

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Yes, it's a fact! Sam's brood of two dozen hens are wearing spectacles —which he bought from a mail-order house in Capitol City.

Sam says it works (and big poultry raisers say so, too). The hens see each other through soft colored glasses, and instead of fighting and picking at each other, they're placid, gain weight, and lay more eggs.

Makes me almost wish we could have rose-colored glasses for human beings, too. So that instead of quarreling and criticizing, like we generally do so much of the time, we'd simply live and let live in contentment.

From where I sit, the human race wastes a powerful lot of time in wrangling over minor issues . . . whether a man should drink beer or cider . . . whether a woman should wear slacks or skirts . . . instead of seeing each other through "spectacles" of tolerance that enable us to live-and-let-live like Sam's brood of chickens.

Joe Marsh

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The following hotels are reserving accommodations for this meeting: Hotel Atlantan, Henry Grady Hotel, Biltmore Hotel, Cox-Carlton Hotel, Imperial Hotel, Clermont Hotel, Piedmont Hotel, Robert Fulton Hotel. We suggest you name your first and second choice and write immediately and we will make reservation for you—The Atlanta Graduate Medical Assembly, 768 Juniper St., N. E., Atlanta, Georgia.

talks to the P.T.A. and various woman's clubs.

4. Cooperate in promoting health education through the various committees of your local county medical society.

5. If you, through research work, find feature stories concerning public medicine, forward the material to the Florida Medical Association's Academy of Public Medicine, Jacksonville, to be processed.

6. Cooperate with your county medical society on exhibit displays at conventions in your home county.

7. Aid in the recruitment of student nurses in cooperation with the nurse and hospital associations.

8. Collect obsolete or discarded medical instruments so that they may be reconditioned and put into service in other places.

9. Cooperate with your county medical society in arranging special "days," such as Doctor's Day, Health Day and Hospital Day.

10. Keep your Auxiliary chairman informed on activities of local programs.

It is very difficulty to enumerate all phases of public relations work. Each community has its peculiar need and the addition of any worth while project would be greatly appreciated, provided, of course, that it has had the approval of the local medical society.

Mrs. James L. Anderson, Chairman
Public Relations Committee

BOOKS RECEIVED

THE SELECTED WRITINGS OF BENJAMIN RUSH. Edited by Dagobert D. Runes. Pp. 433. New York: Philosophical Library, 1947.

This collection of the writings of Benjamin Rush, considered by many the great physician of his country and time, reflects the lifework of this great American in the social and scientific fields, which placed him clearly at the head of the early American fighters for a more wholesome, a more secure, a happier way of living. His uncompromising revolutionary spirit, his burning patriotism, his unflagging zeal in scientific and medical investigations and his tireless quest for social and political justice carry across the two centuries since his birth a needed message for today in these selections from his pen.

THE HEALTHY HUNZAS. By J. I. Rodale. Price, $2.75. Pp. 263. Emmaus, Pa.: Rodale Press, 1948.

Return to the soil everything taken from it—that is the simple, age-old device by which the healthy, happy, buoyant Hunzas, tucked away in the mountain fastnesses of northern India, sustain themselves on their pocket-handkerchief plots of land, flourishing in hardihood and vigor, on into unusual longevity. So the author portrays them. He holds them up as just about the most truly civilized people on earth, an example to the world of soil conservation that pays dividends in a life incredibly devoid of disease, degeneration and crime.



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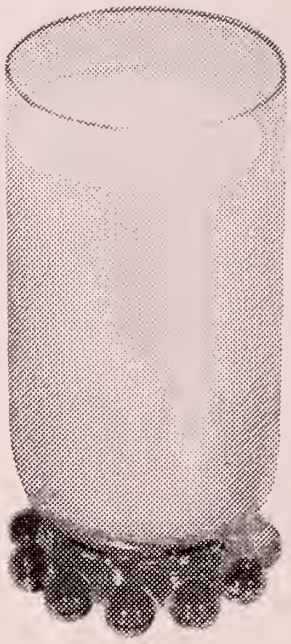
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*Albrecht, F. K.: Modern Management in Clinical Medicine, Baltimore, The Williams and Wilkins Co., 1946, p. 170.

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HOW LAYMEN CUT MEDICAL COSTS. Pp. 35. Chicago: Public Health Institute, 1948.

This little book tells the story of the Public Health Institute of Chicago, a "not-for-profit" venereal disease clinic which, under the able guidance of prominent civic-minded laymen, who serve without compensation, gave 5,973,801 examinations and treatments to 359,496 individual patients or better than 10 per cent of that city's entire population. During the twenty-seven years of its existence, Chicagoans made an average of 4,255 visits to the Institute weekly.

This remarkably successful experiment has demonstrated admirably that private enterprise can provide self-supporting low-cost medicine and that this service need not necessarily become another function of government. For that reason, this account of the Institute's accomplishments should be of particular interest at this time. To insure the perpetuity of the clinic and to fulfil a long-standing desire on the part of the trustees that it should ultimately be owned and managed by the medical profession, they presented its facilities to the Medical School of Northwestern University at the beginning of 1947.

VENOUS THROMBOSIS AND PULMONARY EMBOLISM. By Howard Neuhof, M.D. Price, $4.50. Pp. 159. New York: Grune & Stratton, 1948.

Part I of this monograph, entitled "Venous Thrombosis and Peripheral Pulmonary Embolism," comprises the result of a study of the role of pulmonary embolism as a cause of death among patients at Mount Sinai Hospital, New York, made with a view to working out a plan for its surgical management, which led to the development of an operative approach by way of the right ventricle. The strictly surgical viewpoint on the management of venous thrombosis, tempered by investigation oi anticoagulant therapy, more particularly in the form of heparin therapy, crystallized the viewpoint set forth by the author, who is clinical professor of surgery in Columbia University.

Part II, entitled "Massive Pulmonary Embolism Based in Part on a Study of 88 Fatal Cases," covers etiology, the mechanism of death in pulmonary embolism, illustrative cases, the problem of diagnosis and the treatment of massive pulmonary embolism, and prophylaxis of pulmonary embolism.

The monograph stresses the importance of the study and treatment of venous thrombosis and pulmonary embolism by a hospital team selected for the purpose, since these two subjects remain among the most important in hospital practice.

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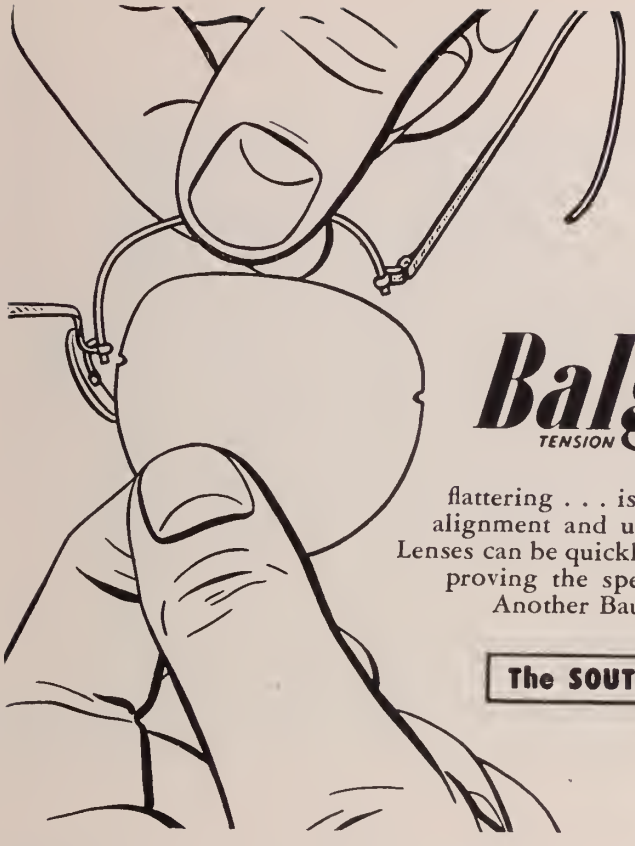
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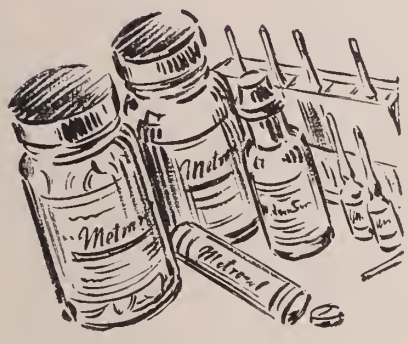
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	Madison-Suwannee	C. LeRoy Adams, Jr., M.D. Parshley Bldg. Live Oak	Irby H. Black, M.D. 918 W. Howard St. Live Oak		9	100%	
	Taylor *Dixie-Lafayette*	Walter J. Baker, M.D. Foley	Ralph J. Greene, M.D. Perry	Last Friday 8:00 P.M.	4	100%	
C	Alachua *Bradford, Gilchrist Union*	J. Maxey Dell, Jr., M.D. 331 W. Main St., S. Gainesville	E. Emory Bell, M.D. Box 400 Gainesville	2nd Tuesday 8:00 P.M.	34	33	B-3-50 Charles C. Grace, M.D. St. Augustine
	Duval *Clay*	John A. Beals, M.D. 1900 Boulevard Jacksonville	Elmer E. Leitner, M.D. 33 W. Ashley St. Jacksonville	1st Tuesday 8:15 P.M.	236	228	
	Marion *Levy*	Hugh H. Barfield, M.D. 1317 S. Orange St. Ocala	Bertrand F. Drake, M.D. Professional Bldg. Ocala	3rd Wednesday 12.30 P.M.	30	27	
	Nassau	David G. Humphreys, M.D. Fernandina	John W. McClane, M.D. Fernandina	Last Friday 8:00 P.M.	9	100%	
	Putnam	Edward W. Ford, M.D. Crescent City	James W. Davidson, M.D. 6 S. Main St. Crescent City	2nd Tuesday 6:00 P.M.	9	100%	
	St. Johns	Hardgrove S. Norris, M.D. 168 Marine St. St. Augustine	S. Raymond Cafaro, M.D. Exchange Bank Bldg. St. Augustine	3rd Tuesday 8:30 P.M.	15	100%	
D	Brevard	I. Kimbell Hicks, M. D. Melbourne	Theodore J. Kaminski, M.D. Box 576 Melbourne	2nd Tuesday	15	13	B-4-49 Rabun H. Williams, M.D. Eustis
	Lake *Sumter*	Howard G. Holland, M.D. 1112 W. Main St., Leesburg	Matthew Arnow, M.D. Eustis	1st Wednesday 7:30 P.M.	26	24	
	Orange *Osceola*	Rollin D. Thompson, M.D. Box 3513 Orlando	James G. Economon, M.D. 108 E. Central Orlando	3rd Wednesday 8:00 P.M.	135	133	
	Seminole	Harry Z. Silsby, M.D. Box 642 Sanford	Frank L. Quillman, M.D. Box 158 Sanford	2nd Tuesday 5:30 P.M.	10	100%	
	Volusia *Flagler*	Charles E. Tribble, M.D. DeLand	Robert L. Miller, M.D. 258½ S. Beach St. Daytona Beach	2nd Tuesday 7:30 P.M.	51	50	570
E	Hillsborough	Douglas D. Martin, M.D. 442 W. Lafayette St. Tampa	Herschel G. Cole, M.D. 315 Wallace S. Bldg. Tampa	1st Tuesday 8:00 P.M.	148	146	C-5-49 John M. Butcher, M.D. Sarasota
	Manatee	Millard P. Quillian, M.D. Walcaid Bldg. Bradenton	Willett E. Wentzel, M.D. Professional Bldg. Bradenton	3rd Tuesday 7:00 P.M.	18	100%	
	Pasco Hernando-Citrus	William G. Mason, M.D. Inverness	W. Wardlaw Jones, M.D. Box 247 Dade City	2nd Thursday 7:00 P.M.	14	100%	
	Pinellas	M. Eldridge Black, M.D. 311 Coachman Bldg. Clearwater	Whitman C. McConnell, M.D. 313 First Federal Bldg. St. Petersburg	1st Monday 6:30 P.M.	152	100%	
	Sarasota	John M. Butcher, M.D. 209 Commercial Ct. Sarasota	Talmadge S. Thompson, M.D. Box 224 Venice	2nd Tuesday 8:30 P.M.	23	100%	
F	DeSoto-Hardee-Highlands-Charlotte-Glades	Zaven M. Seron, M.D. Sebring	Howard V. Weems, M.D. 22 Oak St. Sebring	2nd Tuesday 8:00 P.M.	26	25	C-6-50 H. Quillian Jones, M.D. Ft. Myers
	Lee *Collier, Hendry*	Harvie J. Stipe, M.D. 210 Richards Bldg. Ft. Myers	H. Quillian Jones, M.D. 311 Professional Bldg. Ft. Myers	3rd Tuesday 7:30 P.M.	22	100%	
	Polk	Chester H. Murphy, M.D. Bartow	John W. Vaughn, M.D. Box 475 Lakeland	2nd Wednesday 7:00 P.M.	76	73	479
G	Indian River	James C. Robertson, M.D. Vero Beach	William L. Fitts, 3rd, M.D. Vero Beach Arcade Vero Beach	2nd Tuesday 8:00 P.M.	8	100%	D-7-50 Erasmus B. Hardee, M.D. Vero Beach
	Palm Beach	Victor Clarholm, M.D. Box 672 West Palm Beach	Ralph M. Overstreet, Jr., M.D. 820 Comeau Bldg. West Palm Beach	3rd Monday 8:00 P.M.	89	100%	
	St. Lucie-Okeechobee-Martin	Hugh B. Goodwin, Jr., M.D. Arcade Bldg. Ft. Pierce	Adrian M. Sample, M.D. Box 897 Ft. Pierce	3rd Thursday 8:00 P.M.	13	12	
H	Broward	Milton N. Camp, M.D. 720 Sweet Bldg. Ft. Lauderdale	Alva R. Taylor, M.D. 414 Blount Bldg. Ft. Lauderdale	4th Tuesday 8:00 P.M.	63	100%	D-8-49 Russell B. Carson, M.D. Ft. Lauderdale
	Dade	Robert T. Spicer, M.D. 1110 Huntington Bldg. Miami	Benjamin G. Oren, M.D. 628 duPont Bldg. Miami	1st Tuesday 8:30 P.M.	488	470	
	Monroe	James B. Parramore, M.D. 523 Whitehead St. Key West	Herman K. Moore, M.D. 419 Eaton St. Key West	2nd Thursday 8:00 P.M.	13	100%	674

*Supervise and aid until organized separately.

Total 1912

SCHEDULE OF MEETINGS

ORGANIZATION	PRESIDENT	SECRETARY	ANNUAL MEETING
Florida Medical Association	Joseph S. Stewart, Miami	Robert B. McIver, Jacksonville	Belleair, Apr. 10-13, 1949
Florida Medical Districts	Herman Watson, Lakeland	Council Chairman	
A-Northwest	Irby H. Black, Live Oak	William P. Hixon, Pensacola	
B-Northeast	Rabun H. Williams, Eustis	Charles C. Grace, St. Augustine	
C-Southwest	John M. Butcher, Sarasota	H. Quillian Jones, Ft. Myers	
D-Southeast	Russell B. Carson, Ft. Lauderdale	Erasmus B. Hardee, Vero Beach	
Florida Specialty Societies			
Derm. and Syph., Soc. of	A. Buist Litterer, Miami	Wesley W. Wilson, Tampa	Belleair, April 10, 1949
Genl. Practice of Med.	M. Crego Smith, Clearwater	Walter E. Murphree, Gainesville	Belleair, April 10, 1949
Health Officers' Society	Roger F. Sondag, Jacksonville	Lorenzo L. Parks, Jacksonville	Belleair, April 10, 1949
Industrial & Railway Surgeons	F. Hardy Bowen, Jacksonville	J. H. Mitchell, Jacksonville	Belleair, April 10, 1949
Neurology & Psychiatry	James G. Lyerly, Jacksonville	William H. McCullagh, Jacksonville	Belleair, April 10, 1949
Ob. and Gynec. Society	Chas. J. Collins, Orlando	Dorothy D. Brame, Orlando	Belleair, April 10, 1949
Ophthal. & Otol., Soc. of	Bascom H. Palmer, Miami	W. Jerome Knauer, Jacksonville	Belleair, April 10, 1949
Orthopedic Society	Charles B. Mabry, Jacksonville	Eugene L. Jewett, Orlando	Belleair, April 10, 1949
Pathological Society	James N. Patterson, Tampa	Gretchen V. Squires, Pensacola	Belleair, April 10, 1949
Pediatric Association, State	Edgar W. Stephens, W. P. Beach	Hugh A. Carithers, Jacksonville	Belleair, April 10, 1949
Proctologic Society	Dean W. Hart, St. Petersburg	Frederick E. Farrer, Miami	Belleair, April 10, 1949
Radiological Society	James F. Pitman, Lake City	Floyd K. Hurt, Jacksonville	Belleair, April 9-10, 1949
Urological Society	Milton M. Coplan, Miami	Russell B. Carson, Ft. Lauderdale	Belleair, April 10, 1949
Florida—			
Academy, Public Medicine	Robert T. Spicer, Miami	Shaler Richardson, Jacksonville	Belleair, April 13, 1949
Basic Science Exam. Board	Paul A. Vestal, Winter Park	M. W. Emmel, D.V.M., Gainesville	Gainesville, Nov. 6, 1948
Dental Society, State	Horace L. Cartee, D.D.S., Miami	John I. Todd, D.D.S., Jacksonville	Hollywood, Dec. 12-15, 1948
Hospital Association	Mr. James T. Pate, Jacksonville	Mr. H. A. Schroder, Jacksonville	
Hospital Service Corporation	Mr. W. E. Arnold, Jacksonville	Mr. H. A. Schroder, Jacksonville	
Medical Examining Board	Homer L. Pearson, Jr., Miami	Frank D. Gray, Orlando	Jacksonville, Nov. 29-30, '48
Medical Postgraduate Course	Turner Z. Cason, Jacksonville	Chairman	
Medical Service Corporation	Leigh F. Robinson, Ft. Lauderdale	Herbert E. White, St. Augustine	
Nurses Association, State	Miss Elizabeth Reed, Jacksonville	Miss Helen Shearston, Miami	
Pharmaceutical Association, State	Mr. D. M. Weaver, Miami	Mr. R. Q. Richards, Ft. Myers	
Public Health Association	Turner E. Cato, Miami	Mr. Fred B. Ragland, Jacksonville	West Palm Beach
Tuberculosis & Health Assn.	Judge Ernest E. Mason, Pensacola	Mr. Walton MacJordan, Orlando	May, 1949
Woman's Auxiliary	Mrs. L. E. Parmley, Winter Haven	Mrs. C. R. Morgan, Jr., Miami	Belleair, Apr. 10-13, 1949
American Medical Association	R. L. Sensenich, South Bend, Ind.	Geo. F. Lull, Chicago	Atlantic City, June 6-10, 1949
A. M. A. Interim Session			St. Louis, Nov. 30-Dec. 3, '48
Southern Medical Association	E. L. Henderson, Louisville, Ky.	Emmett B. Carmichael, Atlanta	
Alabama Medical Association	J. Paul Jones, Camden, Ala.	Douglas L. Cannon, Montgomery	Montgomery, Ala., Apr. 19-21, 1949
Georgia, Medical Assn. of	Edgar Hill Greene, Atlanta	Edgar D. Shanks, Atlanta	Savannah, Ga., May 10-13, '49
S. E. Hospital Conference	Mr. Burton M. Battle, New Orleans	Mr. R. F. Whitaker, Atlanta	Biloxi, Miss., April 27-29, '49
Southeastern Allergy Assn.	Clarence L. Laws, Atlanta	Kath. B. MacInnis, Columbia, S. C.	Durham, N. C., Jan. 22-23, '49
Southeastern, Am. College Phys.	Webster Merritt, Jacksonville	Florida Program Chairman	Atlanta, 1948
Southeastern, Am. Urological Assn.	Harold P. McDonald, Atlanta	Russell B. Carson, Ft. Lauderdale	Boca Raton, March 21-24, '49
Southeastern Surgical Congress	Gilbert Douglas, Birmingham, Ala.	S. T. Beasley, Atlanta	Biloxi, Miss., Jan. 24-27, '49

Every available means for checking has been used. Notification of errors or omissions should be mailed to P. O. Box 1018 (Fla. Theatre Bldg.), Jacksonville 1, for use in compiling the next Journal.



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The Journal
OF THE FLORIDA MEDICAL ASSOCIATION

Vol. XXXV DECEMBER, 1948 No. 6

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Volume XXXV DECEMBER, 1948 No. 6

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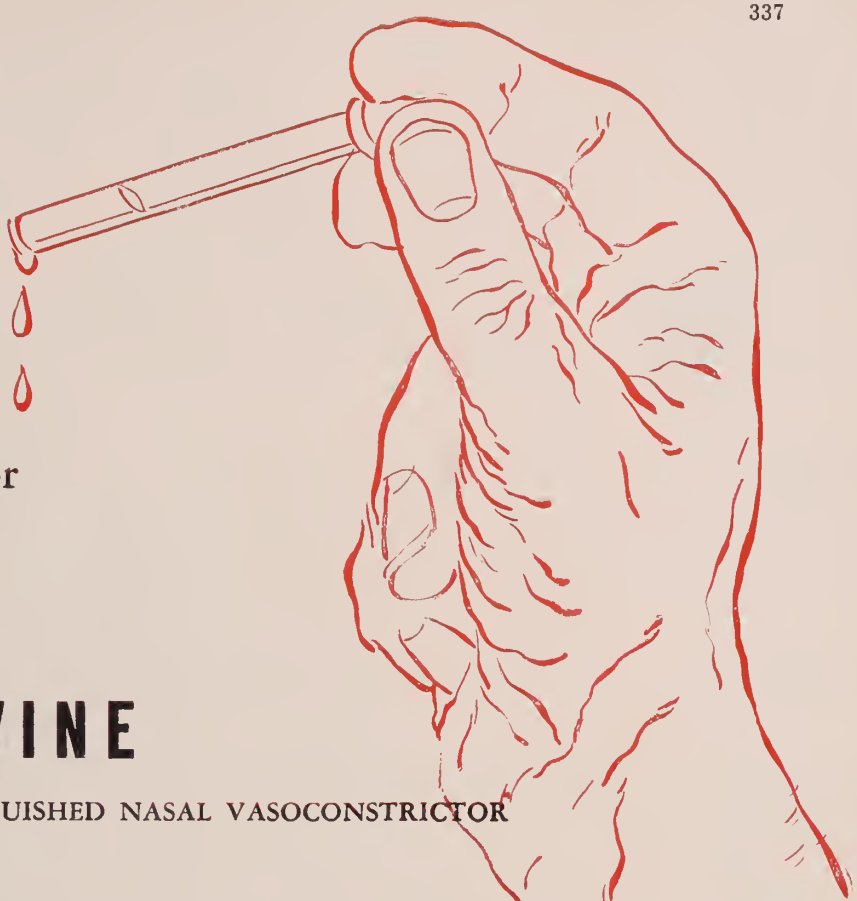
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This Journal is not responsible for the opinions and statements of its contributors.

Published monthly at Jacksonville, Florida. Price $5.00 a year; single numbers, 50 cents. Address Journal of the Florida Medical Association, P. O. Box 1018 (Fla. Theater Bldg.), Jacksonville 1, Fla. Telephone 6-1571. Accepted for mailing at special rate of postage provided for in Section 1103, Act of Congress of October 3, 1917: authorized October 16, 1918. Entered as second-class matter under Act of Congress of March 3, 1879, at the post office at Jacksonville, Florida, October 23, 1924.



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1. Lennox, W. C. (1947), Tridiane in the Treatment of Epilepsy, J. Amer. Med. Assn., 134:138, May 10. **2.** Merritt, H. H. (1947), Recent Advances in the Treatment of Epilepsy, with Particular Emphasis on the Use of Tridione, Arch. Neural. & Psychiat., 57:130, Jan. **3.** Gibbs, F. A. (1947), New Drugs of Value in the Treatment of Epilepsy, Annals Int. Med., 27:548, Oct. **4.** Fetterman, J. L., and Weil, A. A. (1947), Practical Aspects of Epilepsy (with special consideration of epilepsy in children), Med. Clin. N. America, 31:1273, Sept. **5.** Liebert, E. (1947), Treatment of Neurological Disorders with Tridione, Ill. Med. J., 91:311, June.

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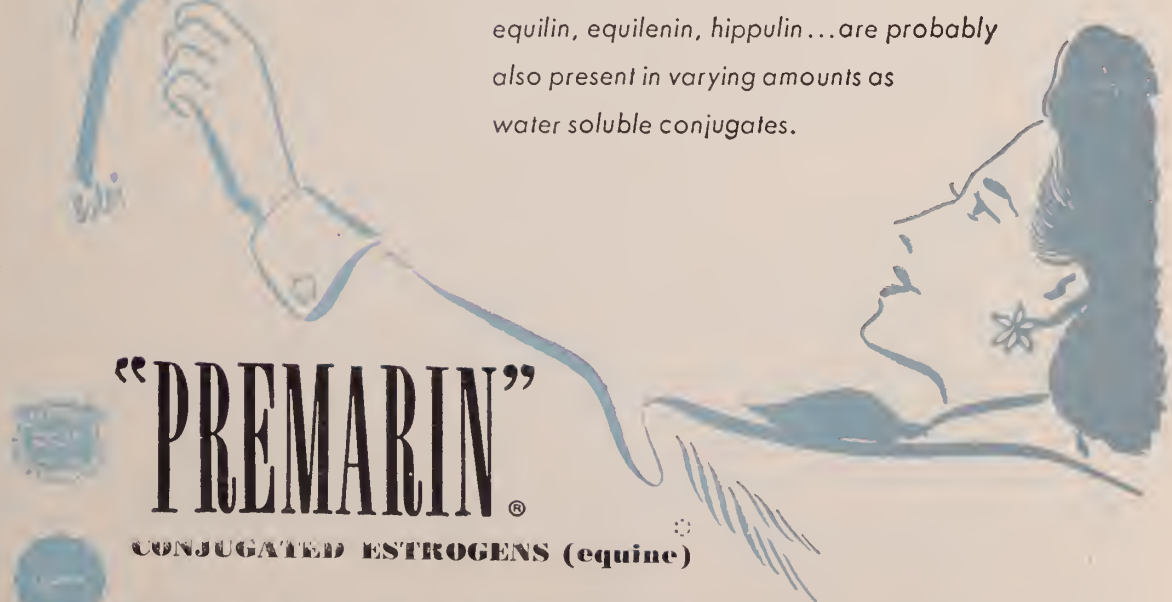


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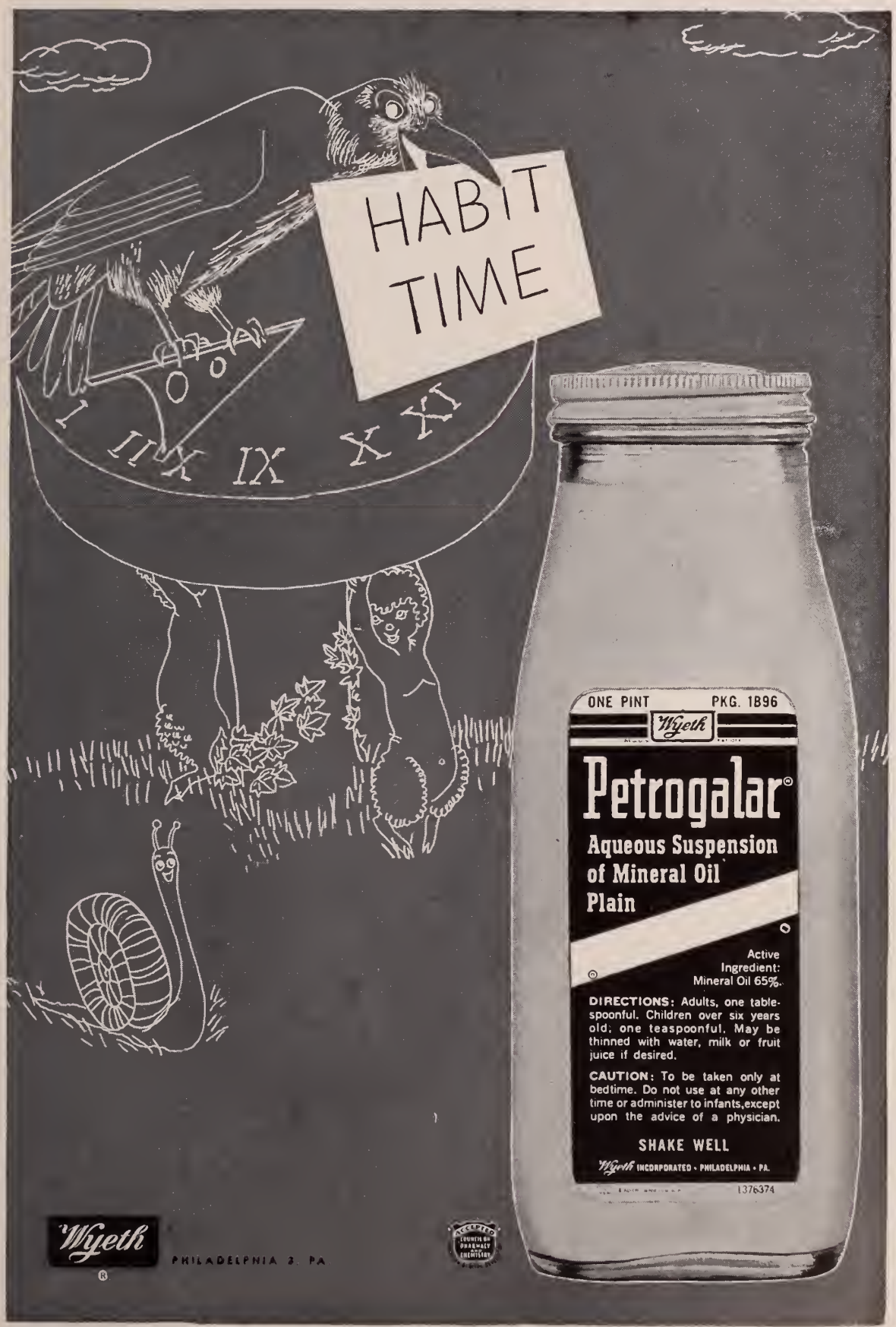
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*Philip Lewin, M. D., F.A.C.S.
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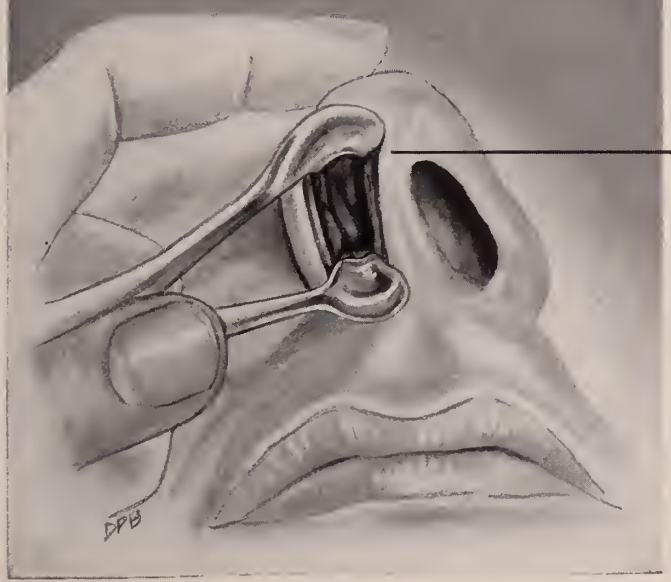
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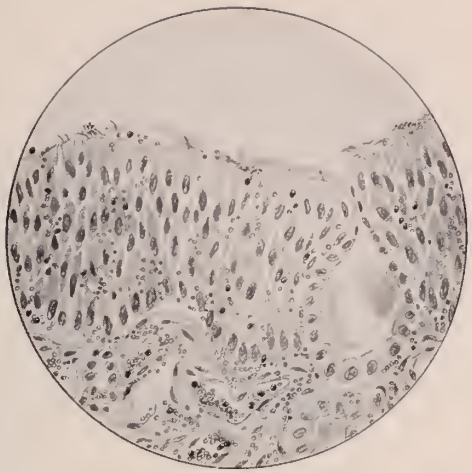
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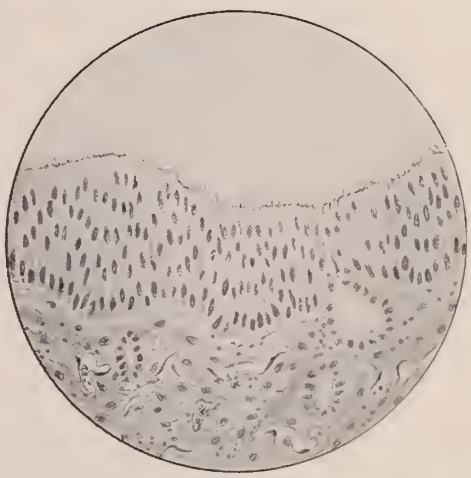
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THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION
PUBLISHED MONTHLY
Volume XXXV Jacksonville, Florida, December, 1948 No. 6

Amebiasis: Electrocardiographic Changes in Patients Treated with Emetine Hydrochloride*

WEBSTER MERRITT, M.D.
JACKSONVILLE

Amebiasis, first described in St. Petersburg, Russia in 1875,[1] has been recognized in this country since 1890, when Osler[2] described the dysentery form of the disease. Dysentery is still the best known form of amebic colitis, but during the past quarter of a century milder forms of amebiasis and the problem of the "carrier" have received more general recognition.[3]

During the past ten years, the disease and its associated problems have held especial interest for the group at Riverside Hospital in Jacksonville. In 1937, the assistant director of the laboratories received specialized instruction in the recognition of protozoa in the stool, and since that time a routine examination has been made of the stool from every patient admitted to the hospital and from every person undergoing medical study in the outpatient department. In the past two and one-half years alone, July 1, 1945 to December 31, 1947, the laboratory workers there have searched for amebae on more than 5,400 stool specimens, which represent nearly 3,400 patients.** One hundred and sixty-four, or 5 per cent of the total number of patients examined, were found to be harboring either the cysts or the motile vegetative forms (trophozoites) of Endamoeba histolytica.

In the group of patients with amebiasis, the records of 140 appear to present sufficient data for analytic study. Of this number, 42 per cent had no gastrointestinal symptoms whatever; another 42 per cent had only vague symptoms of abdominal discomfort, which for the most part apparently were not due to amebiasis; and 2 per cent had pain, diarrhea and blood in the stool, which were clearly due to carcinoma of the colon, ulcerative colitis, and rectal abscess and fissure in 1 case each. Thus it will be seen that of the total number found to be harboring amebae, considerably more than half did not appear to be suffering directly therefrom. Only 18 patients, or 13 per cent, appeared to be having symptoms which could without doubt be attributed to amebic colitis, while only 1 patient, or less than 1 per cent, had symptoms which appeared to be directly due to the acute dysentery form of the disease (fig. 1).

AMEBIASIS—140 CASES

No gastrointestinal symptoms	42%
Vague gastrointestinal symptoms	42%
Griping pain with intermittent diarrhea	13%
Persistent diarrhea with blood due to another disease	2%
Persistent diarrhea with blood due to amebiasis	1%

Figure 1

There is a difference of opinion today over the method of treatment of patients with amebiasis. Early in our experience, because of several patients who were highly refractory to treatment, we believed that all patients should receive emetine. Each was hospitalized, and emetine hydrochloride was given hypodermically while carbarsone, chiniofon or diodoquin was given orally. Later in our experience it appeared to us that many could be treated in the outpatient department without emetine. Of the 140 patients, 59 were treated with emetine while hospitalized, 33 were treated without emetine while ambulatory, and 48 received no treatment or were treated elsewhere. Our present policy, which is to employ emetine in treating only those patients who appear to be suffering from amebic colitis, results in the selection of a larger number for ambulatory treatment.

In the outpatient department, carbarsone and large doses of bismuth subcarbonate on the one hand and diodoquin or chiniofon and large doses of bismuth on the other seemed about equally efficacious. Diodoquin now appears to us to be the drug of choice because of its effectiveness and because it is tolerated well by most patients (fig. 2).

AMEBIASIS—TREATMENT

(Ambulatory Patients)
Diodoquin 0.63 Gm.
t.i.d. for 20 days

Figure 2

Read before the Florida Medical Association, Seventy-Fourth Annual Meeting, St. Augustine, April 11-14, 1948.
*A study of cases observed by the group at Riverside Hospital, Jacksonville, from July 1, 1945 to Dec. 31, 1947.
**There were 5,430 stool specimens and 3,369 patients.

Most of the hospitalized patients were given emetine hydrochloride hypodermically in doses of ½ to ¾ grain twice daily for six or seven days and carbarsone by mouth in doses of 3¾ grains three times daily for seven to ten days. This treatment was followed, after discharge, by 3 drachms of bismuth subcarbonate three times a day. Three fourths of a grain of emetine hydrochloride twice daily for one week is a somewhat larger dose than is generally recommended, but we believed that larger doses were more apt to effect cure in refractory cases, and the incidence of untoward reactions did not appear to be much higher. It is our present policy to administer ½ grain twice daily for six days, always to use this drug when there is active dysentery, when symptoms suggest amebic colitis and when there is blood in the stool, and to use diodoquin concomitantly rather than carbarsone (fig. 3).

AMEBIASIS—TREATMENT
(Hospitalized Patients)
Emetine HCL (H) gr. 1/2
b.i.d. for 6 days
and
Diodoquin 0.63 Gm.
t.i.d. for 10 days
Figure 3

Ipecac was used in the treatment of dysentery more than two hundred and fifty years ago, and emetine, isolated from ipecac more than one hundred years later,[4] was used with indifferent success until the turn of the twentieth century because nonspecific forms of dysentery were treated. Not until 1912, when Rogers[5] made his reports, did the parenteral administration of emetine hydrochloride receive widespread acceptance. In 1916 the dangerous effects of large doses of the drug on the cardiovascular system were recognized when Levy and Rowntree[6] showed by means of the electrocardiogram that an overdose in rabbits caused ventricular fibrillation and death. After that time, however, despite their report, more emphasis was put on neuromuscular symptoms than on changes in the heart. In 1941, Boyd and Scherf[7] demonstrated electrocardiographic changes in experimental intoxication with emetine hydrochloride in cats, while recently Hardgrove and Smith[8] in Canal Zone and Dack and Moloshok[9] in New York presented convincing proof that emetine hydrochloride produces electrocardiographic changes in therapeutic as well as in toxic doses.

As early as 1937, one of our colleagues in Jacksonville, Dr. L. S. Laffitte, recognized profound electrocardiographic changes as being due to a toxic dose of emetine hydrochloride administered prior to the time he saw the patient (fig. 4).

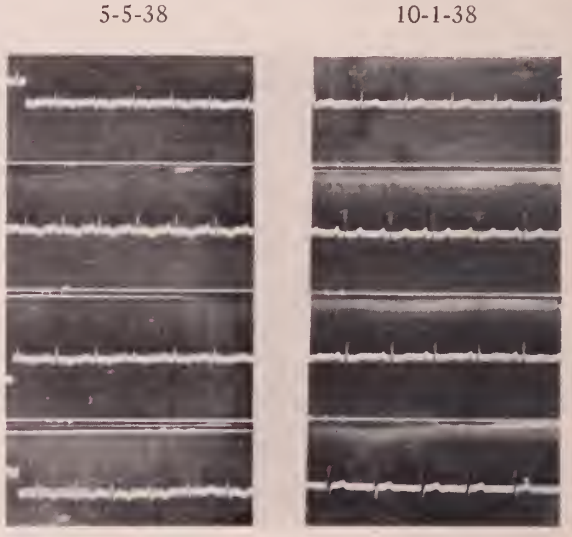


Fig. 4.—Frank inversion of T waves due to toxic doses of emetine hydrochloride.

During the past one and one-half years, July 1, 1946 to Dec. 31, 1947, we have obtained electrocardiographic tracings on 38 patients prior to and following treatment with emetine hydrochloride. All were confined to bed in the hospital, and several tracings were taken on some. Of this group only 26 per cent showed no appreciable electrocardiographic changes following the administration of emetine, while 60 per cent showed very slight to moderate changes (decrease in voltage of T_1 and/or T_2 of .25 to .99 mm.) and 14 per cent moderate to moderately severe changes (decrease in voltage of T_1 and/or T_2 of 1. to 2.5 mm.). See figure 5. None showed severe or pro-

ELECTROCARDIOGRAPHIC CHANGES
38 Cases

None	26%
Slight to moderate	60%
Moderately severe	14%

Figure 5

found changes such as frank inversion of the T waves or block. Those who received larger doses of emetine appeared to show a somewhat higher incidence of electrocardiographic changes than did those who received smaller doses of the drug, but occasionally moderately severe changes were seen with small doses, indicating that individual idiosyncrasy to the drug is an important factor in the production of the electrocardiographic changes.*

*Since Jan. 1, 1948, in 10 cases in which ½ grain of emetine twice daily for six days was used in treatment, the electrocardiographic changes were as follows: very slight to moderate 60 per cent, moderately severe 10 per cent, and no changes 30 per cent.

It is noteworthy that while many clinics report a low incidence of amebiasis, our study of nearly 3,400 cases revealed an instance of infestation of 5 per cent. Craig[3] has estimated the incidence in the country as a whole to be as high as 10 per cent. Many workers have demonstrated that repeated careful examinations of the stool increase the statistical instance of infestation.

Proper evaluation of symptoms presented by patients with amebiasis is important for it indicates whether or not symptomatic relief will be obtained following treatment. We used the patient's symptoms as a practical guide to the type of treatment to employ. In our series, as previously mentioned, 42 per cent of the patients found to be harboring amebae had no outstanding symptoms which could be ascribed to these organisms, while a like number had merely vague symptoms. Only 13 per cent had symptoms highly suggestive of amebic colitis which could be attributed to this disease.

The groups presenting no gastrointestinal symptoms and only vague symptoms were made up of trophozoite passers as well as cyst passers. Among the patients with vague symptoms many were suffering from an irritable colon, so-called nervous dyspepsia and other psychosomatic disorders apparently not due to amebiasis. Treatment of this group with amebicidal drugs usually did not result in any appreciable degree of symptomatic relief.

Our experience indicates that members of the armed forces returning from service abroad are much more apt to be suffering symptomatically from amebic colitis when they are found to be harboring E. histolytica than are members of the general populace. This observation would make it appear that some strains of this organism are more virulent than others. Apparently, however, there are few or no scientific data to support this belief.

Faust's demonstration[10] of active pin point ulcerations in the intestinal tract due to E. histolytica in 13 out of 202 accident cases in New Orleans in which postmortem examination was conducted is surprising. Our experience would indicate that a much smaller percentage of the total populace would be found to have amebic ulcerative lesions. It is important to remember, however, that ulcerative lesions may involve the colon without causing any symptoms whatever.

In an excellent review of the problem of amebiasis published recently, Albright and Gordon[11] deplore the misleading term "cyst carrier" because, they contend, E. histolytica cannot live and multiply in the lumen of the bowel; hence infestation with the parasite always means invasion of the tissues of the wall of the intestine with production of pathologic lesions. They conclude that all patients who are found to have E. histolytica in the stools should receive emetine as well as one of the other anti-amebic drugs. We concur in most of their several conclusions, but tend to agree with Craig[3] and other authorities that it is not necessary to give emetine to every patient with amebiasis. Albright and Gordon[11] present persuasive arguments to support their recommendation, but the practical point remains that most patients with amebiasis who do not have gastrointestinal symptoms and who do not have blood in the stools apparently can be rendered free of amebae without the use of emetine and without much difficulty.

Treatment of active amebic colitis appears to call for both emetine and one of the iodine drugs or the arsenical mentioned previously. Most authorities seem to agree that emetine is the most effective drug for treatment of amebae which have invaded the tissues, while the drugs administered orally seem efficacious for destroying those organisms living superficially within the lumen of the bowel.

In our series 2 per cent of the patients were clearly suffering from disease of the colon other than amebiasis. It seems significant that in those 3 patients having another disease the amebae were found with difficulty, while in the stool specimens of those with active amebic colitis the organisms were readily demonstrated. It follows, then, that when symptoms are full blown and the organisms are found with difficulty, it would be well to look further for the cause of the disease.

At Riverside Hospital we have been on the lookout for both hepatitis and abscess of the liver of amebic origin. In 1 of 2 cases in which amebic hepatitis was suspected, the presence of amebae was proved. Only 1 case of amebic abscess of the liver has been encountered. In none of these 3 cases was E. histolytica found in the stools upon repeated search.*

In our experience, proctoscopic and sigmoidoscopic examinations were not of great value in diagnosing amebiasis. They were of course important aids in diagnosing and ruling out other diseases.

*Recently we encountered a patient with amebic hepatitis whose stools were positive for E. histolytica and whose symptoms were relieved dramatically by treatment with emetine.

While emetine appears to be the most efficacious drug in the treatment of active amebic colitis, its use is attended by some danger. The mechanism whereby emetine produces pathologic changes in the myocardium, and the nature of these changes, still remain a matter of conjecture. At the present time it is important to recognize that changes do occur and that symptoms appear which should serve as warning signals.

Some patients tolerate fairly large doses of emetine without any untoward symptoms, while others manifest muscular symptoms and cardiovascular symptoms and signs after treatment with relatively small doses. It is noteworthy that muscular or neuromuscular symptoms usually precede and are proportionate to the severity of electrocardiographic changes and that in most instances progressive changes do not develop after withdrawal of the drug. In only 1 case in our series did both muscular symptoms and electrocardiographic changes increase in degree after administration of the drug was discontinued, and in this case the symptoms and signs were not alarming.

Although Dack and Moloshok[11] observed progressive and disconcerting electrocardiographic changes in their patients after emetine had been withdrawn, it should be noted that in the cases reported by them the drug had been administered by someone else, apparently no clinical observations had been made before they saw the patients, and the dose of emetine was unknown. It would appear that reasonable doses of the drug, namely, 10 grains per person in a period of one week or ten days and no more in less than six months, should not be exceeded.

If the patient complains of generalized muscular pain or weakness, or even of localized muscular cramps, the physician is justified in discontinuing the drug. Inasmuch as deaths have been reported among ambulatory, improperly observed patients, it would seem advisable not only to observe the patient more carefully but also for the present to require hospitalization and confinement to bed during the period of administration of emetine.

Irregularity of the pulse was not an important sign of emetine toxicity in our series of cases. Lowered voltage of the T waves was by far the most common electrocardiographic change. Usually there was some increase in the heart rate, but the degree of lowered voltage of the T waves could by no means be accounted for on the basis of tachycardia alone. The length of time required for return of this voltage to normal usually was several weeks or longer (figs. 6, 7 and 8).

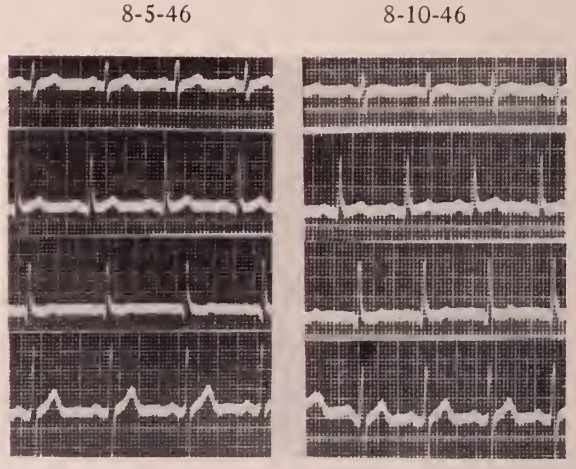


Fig. 6.—Illustrates the group classified as very slight to moderate electrocardiographic changes.

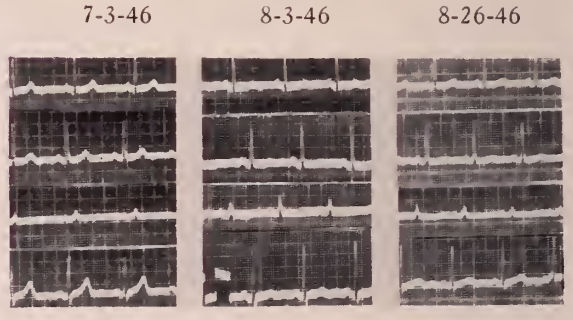


Fig. 7.—Illustrates the group classified as moderate to moderately severe electrocardiographic changes.

SUMMARY

Of approximately 3,400 patients examined in a recent two and a half year period at Riverside Hospital, 5 per cent harbored either the cysts or trophozoites of E. histolytica. Analytic study of the records of 140 of these 164 patients with amebiasis is made. Only 13 per cent had symptoms that appeared to be attributable to amebic colitis, 42 per cent had vague symptoms of abdominal discomfort, and a like number had no gastrointestinal symptoms whatever.

The employment of emetine hydrochloride in the treatment of this disease is reviewed. Hospitalization and confinement to bed during its administration are recommended, and moderation in its use is advised. Experience with this therapy over a period of ten years led to the conclusion that ½ grain twice daily for six days is usually an effective and safe dose, that it appears to be indicated when there is active dysentery, colitis,

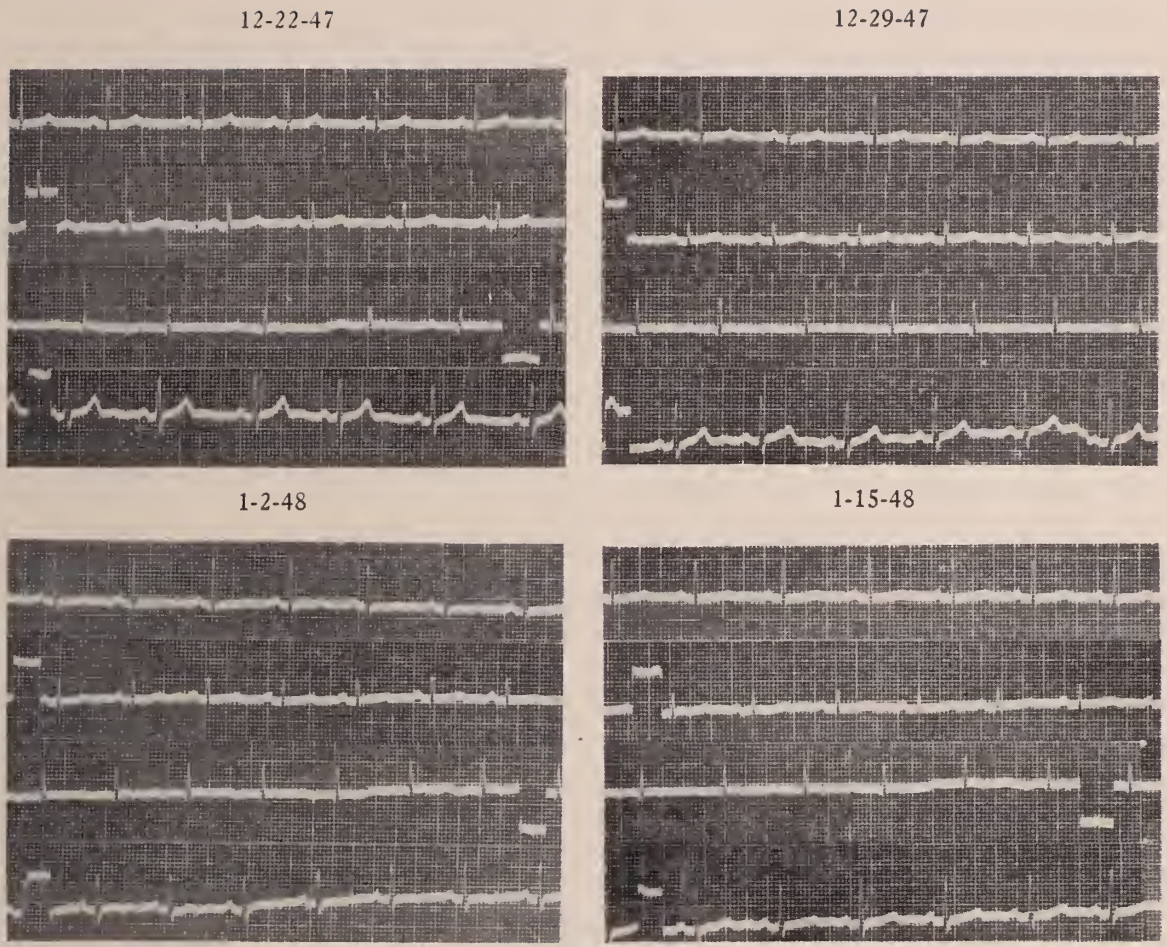


Fig. 8.—Illustrates progressive electrocardiographic changes which occurred after discontinuance of the drug on Dec. 29, 1947.

or blood in the stool, and that diodoquin administered concomitantly appears to be the drug of choice. Oral therapy without emetine usually was effectual in the treatment of asymptomatic amebiasis when there was no blood in the stool.

Electrocardiographic changes incident to treatment with emetine and the warning signals are discussed. Of 38 patients on whom electrocardiographic tracings were obtained prior to and following treatment with this drug, 60 per cent showed very slight to moderate and 14 per cent moderate to moderately severe changes. None showed severe changes. Lowered voltage of the T waves was the only important electrocardiographic change seen.

Muscular symptoms usually precede cardiovascular symptoms and signs. They appear, within reasonable limits of dosage, to be more proportionate to the idiosyncrasy of the patient for the drug than to the size of the dose, although the incidence of changes was lower in the patients receiving the smaller dosage. In most instances prompt discontinuance of emetine therapy prevents progressive changes.

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2033 Riverside Avenue.

DISCUSSION

DR. JERE W. ANNIS, Lakeland: I have nothing of significance to add to Dr. Merritt's excellent paper and to Dr. Borland's discussion. I should like to emphasize two points they have both made. The first is that the method and technic of treatment of amebiasis vary considerably and that we have, after all, still an inadequate treatment for this disease. Secondly, as Dr. Borland pointed out, nothing of significance has been added to the treatment of the disease for many years. We still need an effective drug and must await research work in this regard. The fact that we continue to use a half dozen drugs to treat a single disease is evidence that treatment is not efficient. It is well to remember again that we are using a potentially dangerous drug in emetine, which is a severe protoplasmic poison.

We are still awaiting further research work and electrocardiographic data in following these treated cases, particularly in the interval of one month after the administration of the drug. Case studies of frequent electrocardiograms during this period will be necessary to tell if minor changes do occur during this period and if they occur during an asymptomatic phase. It is my impression that if we follow these patients carefully during such a period after the administration of emetine, we will find greater changes in the electrocardiogram than are now being recorded. As to the clinical significance of such minor changes, we must at the present plead ignorance, but if actual damage is proved to exist, it may well change our routine in the use of this drug.

The Low Sodium Diet

EMIL M. ISBERG, M.D.
MIAMI BEACH

The use of a diet limited in salt content is not a new therapeutic measure. The idea sprung up in Paris[1] at the beginning of this century, and twenty years later it came to be utilized in this country. But acceptance of this therapeutic diet by American medicine has proceeded slowly. Only in recent years has it been generally realized how efficacious a restricted sodium intake can be in the management of edema. The low sodium diet is now recognized as the physiologic basis of the treatment for both the edema of congestive heart failure and "nephrotic" edema. It also appears that stringent sodium restriction may be an effective form of management for some hypertensive patients.

The average human ingests from 2.5 to 6 Gm. of sodium each day. An effective therapeutic diet must contain less than 650 mg. of sodium, and the extent of sodium restriction below that amount will depend upon the therapeutic response in the individual case. The daily diet listed in table 1 contains 200 mg. of sodium. Milk is not included in the list. A glass of milk (200 cc.) contains 100 mg. of sodium; thus by the addition of varying amounts of milk, the basic diet may be altered to any desired sodium content.

Without butter and sugar the diet listed contains approximately 1,300 calories. Sweet butter and sugar contain no sodium; hence they may be added to the individual's daily diet in amounts to obtain any desired total of calories. It is not feasible to include more than 8 tablespoons of butter and 4 tablespoons of sugar; if this amount is included, the diet will contain 2,500 calories.

The purpose of the diet is to restrict the amount of sodium ingested to as low a level as is practical, and at the same time to allow an adequate amount of food to maintain a constant weight.

TABLE 1

A low sodium diet containing 200 mg. of sodium daily is here reproduced through the kind permission of Dr. L. H. Newburgh of the University of Michigan Hospital. Include the following foods daily:

A. 5 ounces of any one of the following:

Beef	Venison
Chicken	Sweetbreads
Turkey	Fish
Lamb	(fresh, unsalted)
Mutton	Bass
Veal	Trout
Rabbit	Halibut
Pork	Cod

B. One egg. (Due to their relatively high sodium content, eggs cannot be substituted for meat.)

C. 3 slices of bread (unsalted).
Commercial bread contains approximatly 100 mg. of sodium per average slice. Care must be taken to be certain that no salt has been included in preparation of the bread used on this diet.
Bread may be omitted entirely. For each slice of bread there may be substituted ½ cup of:
Cooked macaroni (unsalted)
Cooked rice (unsalted)
Cooked farina (unsalted)

D. Potato and cereals. ½ cup of any one of the following, cooked:
Potatoes, white
Macaroni
Spaghetti
Rice
Farina

These are the same articles that may be substituted for bread. If two slices of bread are omitted, the

Read before the American College of Physicians, Southeastern Regional Meeting, Tampa, Dec. 9, 1947.

allowance in this group will be increased by one cup. If one slice of bread is omitted, the allowance in this group will be increased by ½ cup serving as desired.

E. Vegetables. ½ cup of any one of the following:

Asparagus	Lettuce
Green Beans	Mushrooms
Broccoli	Onions
Carrots	Parsnips
Cabbage	Peas
Cauliflower	Tomatoes
Cucumbers	Brussels Sprouts
Eggplant	Salsify
Endive	

Commercially canned vegetables cannot be used due to the additional salt which has been added.

F. Fruits. ½ cup serving of any three of the following:

Apples	Lemons
Apricots	Mulberries
Bananas	Peaches
Blackberries	Pineapple
Cherries	Raspberries
Cranberries	Rhubarb
Plums	Strawberries
Gooseberries	Tangerines
Grapes	Grapefruit
Oranges	Pears

Prunes (fresh or stewed) 3 to 4

G. Jelly: 3 tablespoons.
H. Nuts (unsalted): 50-55 peanuts, almonds.
I. Sugar: As desired.
J. Butter (unsalted): As desired.
K. Salad Dressing: Unsalted vegetable oils may be used.
L. Beverages: Clear coffee, tea, or Kool-aid if desired.
M. Flavoring Agents: Vinegar, pepper, paprika, garlic, vanilla, and lemon juice in small amounts are permitted.

Precautions for the Patient: 1. All foods must be prepared without salt, soda, or baking powder.

2. Beware of salt substitutes; many of them contain sodium.

3. The butter must be sweet butter, or butter which has been washed out and squeezed repeatedly in water.

4. If an excess of the amounts of the foods listed in the diet, other than sweet butter and sugar, is eaten, the daily intake of sodium will be increased. Thus, eat only the amounts of food listed in the diet.

5. Bread and salad dressings must be prepared without salt.

6. Canned vegetables and fruits, unless prepared salt-free, must not be used.

7. Salty appetizers, salted nuts, sardines, caviar, potato chips, olives, pickles, relish, cheese, and smoked or salted meats are not permitted.

8. Many medicines—certain proprietary preparations, sodium bromide, laxatives, sedatives, and antacids for indigestion—contain sodium. It is advisable to take no medicine unless it is prescribed by your physician. One small dose of some medicines may contain more sodium than would be included in the diet in a period of several days.

9. In order for this diet to be effective, the restriction of sodium must be extremely rigid.

The diet has a flat taste, and many patients will object to it at first. But after two or three weeks on this dietary regime, they become accustomed to it and begin to recognize the natural flavors of foods. After several more weeks the diet may even taste good to some persons, and they no longer desire to flavor food with salt.

Fortunately, the water supplies of most cities are so low in sodium that they are entirely suitable for use in low sodium diets. Distilled water must be used by sodium-restricted patients wherever the municipal water supply contains more than 10 mg. of sodium per hundred cubic centimeters. Whenever well water is used by a patient, a sample of the supply should be analyzed for its sodium content. Water treated by a water softener especially contains much sodium and must be avoided.

There is now available a product which is the nutritional equivalent of whole milk powder but which contains only a negligible amount of sodium. Since the commonly used protein foods, meat, eggs, and milk, contain relatively large amounts of sodium, and since foods low in sodium are usually low in protein, this low sodium milk product will facilitate the formulation of a low sodium diet for patients who are in need of a high protein intake.

A patient may be kept on a low sodium diet for years, with no harmful effects resulting from the limited sodium intake. Exceptions to this statement are vomiting, diarrhea and excessive sweating. Also, certain hypertensive, non-edematous nephritic patients have damaged renal tubules with a decreased capacity to do work on sodium, and so excessive amounts of sodium will be lost through the urine. Abnormally low plasma sodium concentration can then result, and this would be accompanied by weakness and anorexia. This is what occurs in Addison's disease. Such patients may be improved dramatically by judicious addition of salt to the diet. On the other hand, undamaged kidney tubules economize sodium efficiently.

Renal Physiology in Relation to Sodium

It has been securely established that the constancy of composition of interstitial fluid and of plasma is maintained by the activity of the kid-

neys. This renal conservation of the constancy of the internal fluid environment of body cells is accompanied by selective tubular reabsorption of the components of the glomerular filtrate. The tubular epithelium does work, and this feature of renal physiology has been clearly explained by Newburgh[2] as follows:

> Some substances are more concentrated in the urine than in the blood while the concentration of other entities is greater in the blood than in the urine. Urea is an example of the first group. Its concentration in the urine is commonly 100 times that of blood. Glucose is the outstanding member of the other group, since its concentration in the plasma is several hundred times that of the urine. Furthermore, it should be emphasized that the ions of sodium and chlorine, whose concentration in the plasma is nearly constant in health, are under certain circumstances more concentrated and under other circumstances less concentrated in the urine than in the plasma. These latter situations may be exemplified by describing certain events in normal man. His plasma contains 3.3 gms. of sodium per liter. If his habitual diet contains this same amount of sodium, he will excrete 3.3 gms. of sodium in the urine each 24 hours (disregarding the small losses through skin and in the feces). And if the volume of urine is one liter, the concentration of sodium in it will be the same as that of the plasma. Hence, no work has been required to keep the plasma sodium at its normal value. Simple diffusion has sufficed. Next, the urine is set at 2 liters without change in sodium intake. The 3.3 gms. of urinary sodium will now be distributed through 2 liters, and therefore its concentration per liter will be half of that of the plasma. This difference has been brought about by the tubule cells which have caused sodium to move from a region of lower, to one of higher concentration. In a third hypothetical situation, the urine volume is one liter again, but the sodium intake is 6.6 gms. daily instead of the previous 3.3 gms. When balance is attained, the urine will contain 6.6 gms. per 24 hours, and so its concentration will be twice that of the plasma. But now the work has caused the urine to become more concentrated than the plasma. So these remarkable tubule cells can cause the urinary sodium to become either more or less concentrated than it is in the plasma, whichever direction guards the fixity of the plasma value.

It is thus seen that when low sodium diets are administered, the work required of the renal tubules is considerable. The kidneys practically stop excreting sodium as soon as plasma levels fall below normal, 320 to 350 milligrams per hundred milliliters or 139 to 152 milliequivalents per liter. Benedict,[3] in his study of prolonged fasting in a human subject who drank only distilled water for thirty-one days, found the amounts of sodium and chlorine excreted in the urine to be as follows:

Period	Sodium	Chlorine
	Gm.	Gm.
First 10 days	5.96	8.44
Second 10 days	0.89	2.13
Third 10 days	0.59	1.57

This represents an average daily loss of only 59 mg. of sodium through the urine during the third ten days of the fasting period. The renal tubular work was so efficient that the urine became almost sodium-free.

Since the human body always excretes about 200 mg. of sodium through the skin each twenty-four hours even in the absence of sweating, and about another 50 mg. in the feces, it is apparent that a daily intake of only 310 mg. is needed in order to maintain sodium balance.

If an abnormally large depletion of body sodium is permitted to occur as a result of the inability of diseased renal tubules to reduce the urinary excretion of sodium to minute amounts, or as the result of vomiting, diarrhea, or excessive sweating, serious disturbances can occur. Marriott[4] completely described the blood changes which occur in salt depletion, as well as the symptomatic pictures of lassitude, apathy, weakness, headache, anorexia, giddiness, stupor, and finally collapse.

It is repeated that no adverse effects will result from the administration of the low sodium diet presented here, provided no undue loss of sodium occurs through the renal tubules, the skin, or the alimentary tract.

EDEMA

In general there are three types of edema: 1. The edema of congestive heart failure, which results from an abnormal rise of the intravascular hydrostatic pressure at the venous end of the capillary; this drives an abnormally large amount of fluid from the plasma into the interstitial space. 2. The "nephrotic" type of edema, which results from a decrease of plasma osmotic pressure due to hypoproteinemia. 3. The edema of increased capillary permeability, which permits the escape of plasma protein into the interstitial fluid; the net protein osmotic pressure within the blood vessels is reduced, and consequently an abnormally large amounts of fluid accumulates in the interstitial space.

Theoretically, edema cannot develop or increase unless both water and sodium enter the body, for each liter of edema fluid contains 3.3 Gm. of sodium. Also, when the intake of sodium is brought below the total loss of sodium from the body, then fluid too is lost from the body, even though there may be an intake of large amounts of water. Without a net increase in body sodium, additional extracellular fluid does not form. Water cannot be retained in the body

unless 3.3 Gm. of sodium is given with each liter of water. Thus water need not be restricted to the patient who is on a low sodium diet.

The restriction of water intake in edematous states, a measure which has been widely practiced for many years, merely causes the extracellular fluid to become hypertonic, for the kidneys are provided with insufficient water to excrete the excess of salt. In consequence, water tends to be sucked out of the tissue cells. Hence the patient, though massively edematous, may actually suffer from cellular dehydration and complain of thirst and dry mouth, as Schemm[7] pointed out. The water in the great pool of interstitial fluid is not available to the kidneys, and thus a policy of water restriction has little influence on the edema but causes oliguria and may produce azotemia.

The really important measure in the treatment of edema, apart from the correction of the fundamental cause of the edema, is the restriction of sodium to a daily intake of not more than 0.625 Gm. The kidneys will not retain water in the absence of sodium, for they obey their fundamental law, as chief regulators of the constancy of composition of plasma and interstitial fluid, that extracellular isotonicity is the prime consideration.

LOW SODIUM DIET IN THE TREATMENT OF CONGESTIVE HEART FAILURE

Eighty years ago Karrell[6] treated his patients who were in congestive heart failure with a diet consisting of 600 to 800 cc. of milk daily, and this often produced diuresis in edematous patients. He did not realize that it was the limited intake of 300 to 400 mg. of sodium daily that was responsible for the beneficial effects.

Achard and Loeper[1] in 1901 demonstrated that salt plays a part in the development of edema by feeding salt to patients in congestive heart failure and thus increasing their edema. Schroeder[7] showed that the restriction of salt was very important in the management of cardiac failure; he pointed out that if the intake of salt was markedly restricted, the intake of water could be raised to as much as 4 liters per day without causing edema in these patients.

It has been shown by Warren and Stead[8] that in some patients with congestive heart failure, an excess of extracellular fluid occurs before any increase in venous pressure is demonstrable. This fact is not compatible with the usual description of the mechanism of forward heart failure previously stated here. They attributed the edema of chronic congestive heart failure to an inability of the kidneys to excrete salt and water in a normal manner. They pointed out that this disturbance in renal function is related to decreased cardiac output and not to engorgement of the kidneys from an increased venous pressure, because the salt and water retention may occur before there is a rise in venous pressure.

In the treatment of cardiac edema it is desired not only to prevent an increase, but also to get rid of the excess amount of extracellular fluid which has already accumulated. Elimination of the excess fluid can be brought about by means of the low sodium diet alone, but this can be facilitated by administering large amounts of an acid such as ammonium chloride. The strong acid is eliminated through the kidneys, and by buffer action, this requires a loss of fixed base—sodium. Then for every 3.3 Gm. of sodium lost in the urine, a liter of water should be lost. Diuresis is thus achieved. There is no point in giving ammonium chloride to the patient in heart failure in order to eliminate sodium, if the dietary intake of sodium is not restricted.[9]

One can justifiably anticipate that edema once removed will not return as long as the patient strictly adheres to the low sodium diet.[2b] The actual amount of sodium permissible is different in different patients, and this must be determined by observing the result of cautious increments of sodium to the basic diet, which contains only 200 mg. of sodium daily.

LOW SODIUM DIET IN THE TREATMENT OF "NEPHROTIC" SYNDROME

The "nephrotic" syndrome results from a decrease of plasma osmotic pressure from hypoproteinemia. Naturally, the primary treatment here must be directed to replenishing the plasma proteins. In the severe generalized edema attained by some of these patients, their bodies may hold more than 100 pounds of excess extracellular fluid. It must be remembered that each liter of edema fluid contains an excess of 3.3 Gm. of body sodium. In order to eliminate the edema fluid, this excess sodium must be eliminated.

The low sodium diet, implemented with large doses of ammonium chloride in order to facilitate removal of base in the urine, thus is indicated in the treatment of the "nephrotic" syndrome. The patient should be continued on the low

sodium diet until his plasma proteins are maintained at normal levels, for Kerkhof[10] demonstrated that it is very difficult to produce edema from hypoproteinemia under experimental conditions if salt intake is restricted.

The harmful effect of low sodium intake in the hypertensive, nonedematous nephritic patient has been described. This does not contradict what has been said about the advantage of sodium restriction in the edematous nephritic patient, because edema implies an excess of body sodium. The nonedematous person is never overloaded with sodium.

LOW SODIUM DIET IN THE TREATMENT OF HYPERTENSION

When Allen[11] introduced the therapeutic measure of dietary restriction of salt to this country in 1920, he was utilizing it in the treatment of patients with hypertension, both "essential" and nephritic. He first presented 20 cases in which blood pressure was lowered in each by limiting the intake of salt. At that time Allen believed that the beneficial effects observed were to be ascribed to chloride restriction. He and earlier French investigators apparently did not appreciate the significance of the sodium ion. In 1922 Allen and Sherrill[12] reported 180 cases of hypertension treated by close restriction of salt intake. Fully normal blood pressure was restored in 18.9 per cent, while in 41.9 per cent there was sufficient improvement to regard the outcome as "a distinct therapeutic success."

Allen's work did not receive general acceptance by the medical profession, but it did receive a storm of opposition and criticism. McLester,[13] Mosenthal,[14] O'Hare and Walker,[15] and Berger and Fineberg[16] conducted independent studies in which hypertensive patients were treated by salt restriction, and each concluded with the belief that salt was of little importance in vascular hypertension. Citing the work of these competent investigators, the editorial columns of the Journal of the American Medical Association[17a,b] in 1923 and again in 1929 warned the profession against the low salt diet for the treatment of hypertension, and hoped that the growing evidence in opposition "ought at least to dampen the ardor of those who are still inclined to bank on the salt-free regimen in hypertension, and encourage them to seek assiduously for more promising and dependable therapeutic possibilities."

Addison[18] was the first to point out that possibly it was the sodium and not the chloride ion which was harmful to hypertensive patients, and he treated his patients with potassium chloride. He found that administration of potassium salts was associated with a drop in blood pressure and a decrease in symptoms of hypertension, and administration of sodium salts provoked a rise in blood pressure and an increase of hypertensive symptoms. It was his belief that the prevalence of hypertension on this continent is in large part due to a potash-poor diet and an excessive use of salt.

For years Allen and a few followers stood alone in their belief of the efficacy of a low salt diet in hypertension. Then in 1945 in the course of their investigation in experimental hypertension, Grollman and Harrison[19a] noted that the administration of diets very low in sodium content to hypertensive rats resulted in a great drop of blood pressure, accompanied by a prolongation of survival. They and their co-workers[19b] then investigated the effect of a diet containing less than 1 Gm. of sodium chloride daily in 6 hypertensive patients. In 2 patients the blood pressure declined to essentially normal levels, and then promptly rose again to pretreatment levels when 20 Gm. of sodium chloride was added to the daily diet. They suggested that a low sodium diet be tried for a brief period in hypertensive patients and be used for a longer time in those patients who display a favorable response.

Kempner[20a,b] advocated a rice-fruit-sugar diet for the treatment of kidney disease and hypertension. This diet contains not more than 150 mg. of sodium, and only 20 Gm. of protein daily. The rice diet led to objective improvement in 203 of 322 patients. Which single factor in this diet—the low sodium content, the low protein content, or the rice—is responsible for the beneficial effects is not definitely known. In evaluating these results it is to be remembered that most of the patients whose results have been reported have been followed for only two to three months, and that only a handful have been followed for more than a year.

Bryant and Blecha[21] recently reported on 100 patients with essential hypertension placed on the diet containing 200 mg. of sodium reproduced in table 1, and followed for periods of several weeks to twelve months. There was significant lowering of pressure to or below 155 systolic and 95 diastolic in approximately 20 per cent of the cases. The majority with hypertensive symptoms showed moderate improvement or were completely relieved.

Thus in recent years there has been renewed interest in the dietary management of hypertension. In another editorial[17c] on "The Treatment of Hypertension" in a recent number of the Journal of the American Medical Association, physicians were advised to test first the value of sodium depletion before recommending sympathectomy for any hypertensive patient.

The mechanism whereby a beneficial effect is induced in hypertensive patients by sodium restriction is not established. It has been hypothesized by some[19,22] that there is an accumulation of salt and water in the tissues of hypertensive patients, a "dry edema," and when subjected to great sodium restriction certain hypertensive patients rid themselves of this salt and water, and that this secondarily results in reduction of blood pressure.

At the present time it appears that the low sodium diet is worthy of trial in the management of hypertension. But as yet no evidence has been presented to show this dietary treatment is capable of arresting or reversing the fundamental course of progressive hypertensive disease.

SUMMARY

The low sodium diet is presented as an important and efficacious therapeutic measure in the management of the edema of congestive heart failure and of "nephrotic" edema.

In the past, the results of this dietary treatment of hypertension have been equivocal, but in recent years the results with more drastic restriction of sodium have been more encouraging and warrant its trial in hypertensive patients.

A basic diet containing 200 mg. of sodium daily is presented. The extent of sodium restriction will depend upon the therapeutic response in the individual case. The actual amount of sodium permissible differs with individuals, and this must be determined by observing the result of cautious increments of sodium to the basic 200 mg. diet.

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541 Lincoln Road.

Seventy-Fifth Annual Convention
Florida Medical Association
Belleair, April 10-13, 1949

Volume XXXV
Number 6

Congenital Defects

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Several years ago congenital malformations were looked on as an act of God. Many pointed to the sins of the parents or grandparents as the cause of these defects. Syphilis stood at the top of the list, for many of the results of the disease were known. The Bible added to this view in its statement regarding the iniquity of the fathers . . . unto the third and fourth generation.

As medical science grew and as insight changed, physicians learned that many diseases are family-linked and race-linked. From this knowledge the science of eugenics has pointed the way to us.

Much spadework has been done in finding the cause of congenital malformations, but there still remains an extremely large number of malformations about which nothing is known. This absence of knowledge presents a challenge to all of us, and it is through careful observation and research that the final answer to these deformities may be found.

According to Arey,[1] the incidence of major malformations in the newborn is about 1 in every 165 births. The ratio is still higher in aborted fetuses, while the inclusion of minor abnormalities would raise the frequency for both groups. This author stated:

> The ancients regarded supernatural means as effective in bringing about monsters. "Nature creates monsters for the purpose of astonishing us and amusing herself" (Pliny). A trace of this idea remains in the languages of the world through expressions like the English "sport" or "freak of nature." At another period it was held that the reason for the birth of deformed infants was to warn, admonish, or threaten mankind against calamity. The word monster is derived either through the Latin "monere" (to warn) or "monstrare" (to indicate). Tablets in Asshurbanipal's library at Nineveh, 2000 B.C., record in cuneiform inscriptions lists of monstrosities then recognized and the events they were alleged to herald. The supposed influence of the stars, evil spirits and kindred supernatural agencies requires no comment.
>
> Intercourse during the menses was another idea of causation: a mythological example is the misshapen Vulcan (ugly and deformed). Warnings against this practice occur in the sacred writings of different peoples, as in Hebrew: "menstrous women shall bring forth monsters." Sexual congress between man and lower animals has also had its advocator, and mythology furnishes examples, like Chiron the Centaur (half man, half horse), of such hybridity.
>
> Finally must be mentioned the alleged results of mental impression (favorable or unfavorable) on pregnant mothers. The effect of fright and other experiences read into subsequent happenings has been a common belief of all peoples at every period of history, including our own. Illustrations of this superstition are found abundantly in sacred writings (Genesis), drama (Merchant of Venice), novels (Elsie Venner) and village lore. Efforts to discredit a belief in the delicacy of maternal impressions meet with singular resistance because of the striking nature of occasional accidental coincidences. Not only is there no anatomical basis for nervous communication between mother and fetus, but most experiences occur quite too late anyway, since the body is well laid down by the second month even before a mother is aware of being pregnant.

Read before the Sarasota County Medical Society, Feb. 10, 1948.

In reviewing over 300,000 births, DePorte and Parkhurst[2] noted that 1 per cent were reported with congenital malformations on the birth certificates. This figure, they believed, should be about doubled because of the reports from crippled children's clinics and from death certificates. They also stated that congenital malformations multiply by at least thirteen times the risk of the child dying in the first month of life.

At present there are numerous known causes for congenital defects, and some probable causes that are highly suspicious. Hereditary factors, infectious diseases, diet, endocrine disorder, poisoning either by radiation or by drugs, ill health of parents and asphyxia probably cover the more modern common causes. Thus it is obvious that numerous causes for malformations have been postulated. Many of these play a big part, others play a lesser part, and most probably other causes will be found through careful observation of the pregnant mother.

During the first three months, that is from fertilization of the ovum till four months of age, the developing fetus goes through multiple intricate changes. The embryo, at three weeks, is about 1.5 mm. long. Few of the organs have begun to appear, and little more than the neural groove is differentiated.

At four weeks the length is 2.5 mm. The body begins to separate from the yolk sac, and structures begin to appear. The optic and auditory placodes are indicated; the neural groove is closing; the heart tube fuses and bends in an s shape; the pronephric tubules are formed; and the foregut and hindgut are present.

At five weeks the length has doubled and is 5.5 mm. The tongue and pharyngeal pouches form; the liver, pancreas and intestine are forming; the trachea and lung buds become prominent; the pronephros degenerate, and the mes-

onephric tubules are formed; the aorta fuses, the aortic arches are completed; the heart shows sinuses, ventricle, atrium, and bulbus; mesodermal segments are present; the neural tube is closed; and the optic and lens cups are formed.

At six weeks the length is again doubled, being now 11 mm. Sense organs appear; the thyroid becomes solid; the thyroglossal duct atrophies; the cecum becomes prominent; the intestines elongate; the atrium, ventricle and bulbus portion of the heart are being partitioned; and muscle segmentation is largely lost.

At eight weeks the length is 25 mm. The digits are well formed; the intestinal villi are developing; the lung begins branching; the plural and peritoneal cavities are forming; the diaphragm is completed; and the fetus is capable of some movement.

At twelve weeks the length is 69 mm. The sex is readily determined; the palate fusion is complete; bile is secreted; pancreatic islands appear; blood formation begins in the bone marrow; and the brain and eye have attained their general structural features.

At sixteen weeks the length is 120 mm. The face looks human; the omentum fuses; the kidneys attain their typical shape and structural plan; the heart musculature is nearly complete; the nose, ears and eyes approach their typical appearance.

Thus in a period of thirteen weeks the embryo has rapidly changed from a rather undifferentiated cellular structure to a fairly well differentiated and fairly normal-appearing human fetus.

The exact cause of the malformation is not always known. Yet it will become increasingly clear from the following discussion that many of the causes of congenital malformations are known and through careful observation more causes can be found.

Today we know that cleft palate, harelip, clubfoot and similar characteristics are family-linked. Murphy[3] pointed out that in families already possessing a malformed child, the rate of subsequent defective offspring is approximately twenty-four times greater than in the general population, and that subsequent malformations are duplicated in nearly one half of the instances.

Thus it is apparent that many congenital malformations are familial-linked and in many instances are the direct results of marriage between two defective persons. When the deformity is carried as a dominant characteristic, the following holds true:

Parents			Children
Homozygous	plus	homozygous	equals all abnormal offspring
Homozygous	plus	heterozygous	equals all abnormal offspring
Homozygous	plus	normal	equals all abnormal offspring
Heterozygous	plus	heterozygous	equals ¾ abnormal, ¼ normal
Heterozygous	plus	normal	equals ½ abnormal, ½ normal

Inherited as dominant conditions are multiple exostoses, osteopsathyrosis, sicklemia, Huntington's chorea, spherocytemia, night blindness without myopia, coloboma iridis, neurofibromatosis and aniridia. In addition, certain forms of the following conditions may be inherited in a dominant manner: epidermolysis bullosa, polydactyly, syndactyly, Friedreich's ataxia, cerebellar ataxia, peroneal atrophy, diabetes mellitus, diabetes insipidus, myotonia congenita, spina bifida, progressive muscular dystrophy, harelip, split hand, cleft palate, microphthalmus, glioma retinae, optic atrophy, hereditary spastic paraplegia, chondrodystrophy, and brachydactyly.[4]

In case of recessive traits, the congenital defect does not always reveal itself unless the mother and father have the same recessive defect.

Parents			Children
Heterozygous	plus	normal	equals ½ carry, ½ normal offspring
Homozygous	plus	normal	equals all carry
Heterozygous	plus	homozygous	equals ½ show, ½ carry
Heterozygous	plus	heterozygous	equals ¼ show, ½ carry, ¼ normal
Homozygous	plus	homozygous	equals all show

Thus it is easy to see why the intermarrying between families tends to reveal the recessive congenital defects by uniting the recessive traits. Diseases related to the recessive gene are albinism, deaf-mutism, Gaucher's disease, Tay-Sachs' disease, Niemann-Pick's disease, alkaptonuria, amyotonia congenita and congenital ichthyosis. Certain forms of the following can also be inherited as recessive traits: diabetes mellitus, polydactylism, chondrodystrophy, microcephaly, harelip and cleft palate, spina bifida, microphthalmus, otic atrophy, glioma retinae, cerebellar ataxia, Friedreich's ataxia, hereditary spastic paraplegia, progressive muscular dystrophy, peroneal atrophy, myotonia

congenita and epidermolysis bullosa.

Besides this group there is still another that is sex-linked, a relation similar to hemophilia. Here conditions are female-carried, but they present as lesions in the male. Hemophilia, color blindness, Leber's optic atrophy, peroneal atrophy, microphthalmus, night blindness with myopia and the anhidrotic type of ectodermal dysplasia actually are such sex-linked traits.

The detection of the genetic carriers[5] of family-linked congenital diseases is of great importance. If we can recognize them, perhaps we can aid in the prevention of the union of the abnormal genes and thus prevent these unfortunate conditions from existing.

Sicklemia is a carrier of sickle cell anemia in the Negro race.

Spherocytosis, ulcers of the leg, cholelithiasis and splenic or hepatic enlargement may be recessive characteristics of familial hemolytic jaundice. In a local case, with this condition proved in the mother, two daughters have large spleens and at times are anemic.

Blue sclera, long gracile bones, deafness, frequent dislocations and multiple fractures are recessive characteristics of mesenchymal dysplasia. In a local case of blue sclera, deafness is present in the mother, and blue sclera and fractures occur in the daughter.

Epilepsy can frequently be detected in the parents through the wave pattern found on the electro-encephalogram and is carried as a recessive trait. Other diseases such as gout, thalassemia and xanthomatosis have their recessive traits.

RH FACTOR

The Rh factor is another condition which results in abnormal children. The Rh-positive father has a child by a sensitized Rh-negative mother. Erythroblastosis may develop and result in anemia, a poorly developed child or death. Besides this condition, kernicterus may develop, which results in a mentally inferior spastic child.

Snyder[6] reported that by statistics erythroblastosis should occur in 8.32 per cent of all births, but it occurs in about ½ of 1 per cent, or about once in every 200 births. In investigating the blood of undifferentiated feebleminded, this author found that of 169 mothers of feebleminded children, 38 were Rh-negative, whereas only 21 or 22 should be expected to be. Thus it would seem that some immune body of the mother produces effects on the brain tissue instead of or besides the usual recognized erythroblastosis.

ENVIRONMENT

The work of Petersen and Mayne[7] indicates that congenital malformations are influenced, to some degree, by temperature and barometric pressure.

AGE

Murphy[8] stated that parental age influences the production of defective offspring, but only after 30 years of age. When the mother is 40 years of age, the birth rate of congenitally malformed children is approximately three times the rate observed when mothers are 30 or less years old. Murphy[8] stated that malformed children are born more often to older mothers and that later pregnancies are more likely to result in malformed children. The maternal peak age for mothers producing mongolian idiots was 41, while the general peak of maternal age in 1934 was 24, according to Bleyer.[9] At the local crippled children's clinic, 20 per cent of the mothers were 35 years of age or older at the time of birth of the defective child.

ASPHYXIA

In discussing causes of malformations one has to remember that many of the so-called abnormal conditions that are seen later in life are the direct result of asphyxia at birth. These abnormalities may arise from a multitude of conditions such as knots in the umbilical cord, cord tied around the neck of the fetus, premature separation of the placenta, prematurity, narcotized babies or any obstruction of the newborn infant's breathing passages.

In 2,006 births, Lund[10] found that 2.2 per cent had severe asphyxia with cyanosis and 6 per cent had moderate asphyxia. Russ and Strong[11] reported that anoxemia is responsible for 18.5 per cent of all deaths in newborn infants. Also they stated that anoxemia prolonged for over two minutes after delivery will cause severe cerebral changes. Schreiber[12] and others have collected much evidence to indicate that a human central nervous system, although capable of survival after anoxemic insults, may often be rendered incapable of achieving normal function.

In a series of 99 cases of mental deficiency with cerebral atrophy, proved by encephalogram, Faber[13] found that in about 20 per cent of the cases there was placental separation (bleeding), including placenta previa, which caused impairment of the fetal oxygen supply and resulting damage. Toxemia associated with infarction or

premature separation and maternal cyanosis caused either by decompensation or pneumonia reduced the fetal oxygen and apparently resulted in fetal injury.

DIET

In his report Murphy[3] showed that in his series congenital malformations were more common among those having low social status and that 40 per cent of mothers of malformed children had defective diets. Burke, Beal, Kirkwood and Stuart[14] made a nutritional analysis of the diets of 216 women observed throughout pregnancy. The offspring of 31 mothers on a good or excellent diet included 1 baby with an anomalous development of the heart. Congenital anomalies were noted in 8 infants born to 36 women whose diet had been poor or very poor. They included instances of heart disease, cataract, mental retardation, cleft palate and hydrocephalus.

Stuart[15] showed that babies born of mothers on poor diets were definitely smaller than those on good diets and that congenital defects were present in 6 per cent of the children whose mothers had been on poor diets. In his study, Parsons[16] showed that poor diets increased congenital defects and stillbirth, and in the same group improved dietary conditions resulted in fewer stillbirths and congenital defects.

Smith[17] reported that during the six or seven months preceding the liberation of northwestern Holland in May 1945, a state of generalized undernutrition was present. This resulted in amenorrhea, fewer conceptions and fewer babies. The babies born weighed less at birth and were shorter. Most important was the observation that a slight but statistically insignificant increase in malformed children occurred.

DISEASE

An old wives' tale[18] stated that "if a mother has German measles while pregnant, it will settle in the baby's eyes." In this disease, folklore and superstition have anticipated by generations the establishment of scientific fact.

In 1941, Gregg[19] reported on congenital cataract in 77 children whose mothers had rubella (German measles) in the first trimester. Forty-four of these infants also had congenital heart disease. Fox and Bortin[20] indicated by their work that a considerable number of normal babies were borne by mothers who had rubella in early pregnancy.

Greenthal[21] reported 2 cases with congenital deafness in one and cataract, mental retardation and malformed heart in the other following maternal rubella in the first trimester. Adams[22] reported 2 cases with cataract and malformed heart in each. Dogramaci and Green[23] reported congenital heart disease following pneumonia, pyelitis, streptococcic infection of the throat, infected teeth and cystitis. In 2 cases of congenital heart disease the mother had syphilis.

Ingalls and Davies[24] reported 6 cases of mongolism in which the mothers had infections in the first trimester. Influenza, rubella, mumps, mastoiditis, pleurisy and acute otitis media with sinusitis were noted.

Erickson[25] reported 11 cases of congenital malformations following maternal rubella in early pregnancy. The malformations were mainly found in the eye and the heart.

Laforet and Lynch[26] reported a case in which the mother had varicella (chicken pox) when eight weeks pregnant; the resulting child had multiple abnormalities.

Dogramaci and Green[23] reported on congenital malformations following maternal poliomyelitis, rubella and virus grip. They also reported no malformation following mumps and scarlatina in the first trimester.

Syphilis has long been blamed for congenital defects. According to Rudaux[27] hydrocephalus, anencephalus, spina bifida and deformities of the nervous system frequently are due to this disease. Moore[28] reported that prior to antisyphilitic treatment 34.4 per cent of all fetal deaths were due to syphilis. The stigma of congenital syphilis is well known, and we must guess that the more severe cases are lost prior to birth. Imbecility is rarely a stigma of congenital syphilis except in neurosyphilis.

According to DeLee's textbook,[29] typhoid interrupts pregnancy in two thirds of the cases, especially in the early months. Smallpox produces abortion in the majority of cases. Measles interrupts pregnancy in about 55 per cent of the cases. Cholera results in frequent abortions. Influenza, during the epidemic of 1919, produced abortion in 25 to 40 per cent of all cases.

These conditions have killed the fetus, but what of the multitude of minor illnesses? Could they not leave their mark on the fetus with resulting congenital malformations in a manner comparable to the action of a relatively minor disease like rubella? Should we not regard each minor illness in early pregnancy as a potential danger to the developing child?

ENDOCRINE DISORDERS

Endocrine glands generally have little known effect upon the developing child. Cretins are usually normal at birth, apparently having been supplied thyroid by the mother during pregnancy. The symptoms of the condition develop in the child from three months to six months after delivery. It is important to mention, however, that the incidence of cretins (endemic) has been lowered by the use of thyroid in the mother and the more general use of iodine in the diet. Thus this therapy prevents this form of congenital defect from developing.

With poor prenatal and postnatal care, infant mortality in diabetic mothers reaches 50 to 70 per cent. The cause of this high mortality is not known. The babies[30] are larger than average; hyperplasia of the islands of Langerhans, cardiac hypertrophy, excessive amount of hemopoietic tissue in the liver and erythroblastosis are found on examination. Good prenatal and postnatal infant care has reduced this mortality to 12 to 20 per cent.

The adrenal glands seem to have a definite relation to malformations. Brown[31] suggested that the virus of German measles in early pregnancy renders the embryonic adrenal cortex defective. The result of this defect is failure of the development of the brain, and anencephalic monsters occur. Usually the fetal adrenal gland is proportionally very large, but it is small or absent in anencephalic monsters. Multiple other abnormalities accompany hypoplastic adrenal glands or the absence of these glands, but the failure of the brain and cranial vault to develop is the most common defect.

POISON

Dogramaci[23] reported concerning ptomaine poisoning in a mother in the first months of pregnancy with resulting congenital defect of the heart in the child. Four mothers with allergy in the early trimester had children with congenital heart disease. One mother had thyrotoxicosis during the first two months of pregnancy, and her child had congenital heart disease.

In 3 cases the mothers were exposed to lead while painting during early pregnancy and later had children with congenital abnormality of the heart. Hamilton[32] and Cantarow and Trumper[33] showed that the offspring of fathers exposed to lead had an unusually high stillbirth rate, and the European literature indicates that stillbirths and miscarriages are excessively high in the wives of men working in lead industries. Weller[34] showed that male guinea pigs exposed to lead were not sterile, but the young fathered were definitely inferior. They developed slowly, and the death rate was high.

The claim has been made that the administration of quinine to the mothers to induce labor may cause deafness in the child, and this possibility is supported by experimental investigation.[35] Taylor[36] reported on the use of quinine in 5 pregnant women at seven months, eight months, four and one-half months, four and one-half months and eight hours before delivery. This therapy resulted in deafness or tinnitus in the mother. All of the pregnancies resulted in children with no hearing.

TRAUMA

Trauma to the mother is seldom a cause of congenital malformation except as it might cause a premature separation with resulting partial asphyxia and injury to the brain. Frequently malformed arms and legs and apparently amputated limbs are blamed on intrauterine bands, adhesions or kinks of the umbilical cord. These types of abnormalities are as a rule strongly inherited. On the other hand, the wrapping of the umbilical cord around the neck of the child is not an infrequent complication and may result in asphyxia, injury to the brain and sometimes death of the child.

VITAMINS

Hale[37] produced multiple congenital lesions in animals by using diets low in vitamin A. Blindness, harelip, misplaced kidneys and absence of the eyeball were the most common lesions. Warkany and Schraffenberger[25] showed that in rats the production of congenital defects is definitely affected by the presence or absence of riboflavin and that there are certain critical periods when this vitamin exerts its influence.

ROENTGEN RAY EXPOSURE

Roentgen rays may be used to produce abortion in the first three to four months of pregnancy; the usual dose given is below that necessary for sterilization. It is known that the more immature and rapidly growing a tissue is, the more susceptible it is to roentgen rays. The fetus is growing rapidly, and the tissue is immature. Goldstein and Murphy[39] in 1929 collected reports on postconception radiation limited to the first four months. They had 75 cases in their series; 38 of the children were unhealthy, and 28 had congenital defects. Microcephalic idiocy was the most frequent type of defect. The earlier radiation was

given the more severe the defect. Preconception radiation for sterilization, or for other reasons, apparently has no effect on the subsequent babies. Frick[10] indicated, however, that roentgen therapy over the ovary may affect the genes and result in future malformations. He described a case that seemed to indicate this conclusion. Animal experimentation demonstrates that larger doses of roentgen rays may cause mutation in the first filial generation in mice.

CASES OBSERVED

During the past two years in the hospital there were 750 births, and from this group 18 cases fit into the condition of this paper. In 12 there were definite malformations, and how many other minor abnormalities occurred is hard to say.

There were 3 cases of hydrocephalus. One mother was a hypothyroid, and one mother had a rather severe cystitis in early pregnancy. The other mother was apparently normal. In 2 cases the infants were microcephalic. One mother had had slight roentgen ray exposure in early pregnancy. No known cause in the other was found.

The 1 case of congenital syphilis resulted in death. There were 6 cases of congenital heart disease. In 3 the condition was familial; in 1 the mother was elderly; and there was no apparent cause in the other 2. There were 4 cases of erythroblastosis. In 2 cases death resulted. There was apparent recovery in 1 case, and in 1 the prognosis was doubtful. One case of an omphalocele occurred with the cause unknown. There was also 1 case of hypothyroidism with the cause unknown.

PREVENTION OF MALFORMATIONS

1. Prevent intermarrying of families.
2. Prevent persons with dominant congenital disease from having children.
3. Prevent women carrying sex-linked disease from having children.
4. Test and take precautions when there are Rh-negative mothers and Rh-positive fathers.
5. Advise child-bearing age in the twenties; avoid late pregnancies.
6. Avoid oversedation of the mother and narcotizing the child.
7. Clear child's air passages as soon as possible and establish normal breathing at the earliest possible moment.
8. Use oxygen and, if necessary, stimulants for the child, but avoid further shock.
9. Stress adequate maternal diet before and during pregnancy.
10. Let female children have common childhood virus diseases during childhood.
11. If a pregnant mother is exposed to contagious disease to which she is not immune, use immune serum to try to prevent disease.
12. Have the pregnant mother try to avoid all possible complications in early pregnancy.
13. Correct any thyroid disturbance in early pregnancy.
14. Keep the diabetic mother on strict regulations throughout pregnancy.
15. Avoid any exposure to lead or other heavy metal.
16. Avoid using any toxic or poisonous drug in any stage of pregnancy.
17. Avoid exposure to roentgen rays or atomic bombs.

CONCLUSION

An attempt is made in the presentation of this paper to point out the extremely rapid growth and intricate tissue changes that take place in the developing embryo.

The more immature a tissue is the more sensitive it is to roentgen therapy. Similarly, the infantile developing tissue is apparently extremely sensitive to any change that may take place, be it of infectious, anoxemic, poisonous, or radiative origin.

The role of hereditary influences, infections, vitamins, general nutrition, age of patient, general toxic substances, roentgen ray exposure and anoxemia has been briefly discussed as have the general precautions that should be taken to prevent malformation of children.

Many reasons for congenital malformations are known today; also there are a great many suspected causes. The common causes are summarized.

The task of the physician is to be observant and to find the causes of these defects; secondarily, it is to find methods to prevent the birth of children with abnormalities.

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Peritoneal Dialysis in the Treatment of Acute Uremia

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Although the principle of peritoneal lavage as a temporary substitute for kidney function is not new, renewed interest in extrarenal dialysis has recently made this principle of practical value.[1,2]

In 1914 Abel, Roundtree and Turner[3] reported a method by which diffusible substances could be removed from the circulating blood by dialysis through a colloidin membrane (a forerunner of cellophane). In 1923 Ganter[4] and Putnam[5] reported the use of the peritoneum as a natural semipermeable membrane by intermittently injecting hypotonic solutions into the peritoneal cavity. Fine, Frank and Seligman[6] in March 1945 described a method of treating uremia by continuous lavage of the peritoneal cavity in order to promote dialysis through the peritoneal membrane.

We wish to report an instance of uremia in which peritoneal dialysis was successfully employed.

Read before the staff of the Tampa Municipal Hospital, Tampa, May 11, 1948.

REPORT OF CASE

A 24 year old unwed nurses' aide was admitted to the hospital complaining of bloody diarrhea, nausea, vomiting, fever, malaise and generalized abdominal tenderness of five days' duration. At the onset of the illness she had been treated in another hospital, where on admission urinalysis had given negative results and the blood count had revealed a leukocytosis of 21,250. Intravenous fluids and penicillin had been the only therapy.

Physical examination revealed a well nourished but dehydrated, acutely ill, nauseated young woman. The ocular fundi were normal. There was no injection nor ulceration of the pharynx. The heart and lungs were normal, blood pressure 126 systolic and 80 diastolic, pulse rate 92 and temperature 100 F. The abdomen was generally tender and slightly distended, but there was no rigidity, and no masses were noted. The pelvic examination gave

negative results. There was slight costovertebral tenderness bilaterally, but the remainder of the examination gave essentially negative evidence.

A urine specimen could not be obtained on admission, and after intravenous administration of 3,000 cc. of fluid in twenty-four hours, catheterization revealed no urine in the bladder. A blood urea nitrogen determination was 50.4 mg. per hundred cubic centimeters of blood. Culture of the stool yielded only colon bacilli. Study of the blood revealed 4,010,000 erythrocytes, 17,550 leukocytes, and hemoglobin 11 Gm. The Kahn reaction was negative.

The patient denied having taken a mercurial salt, but subsequently it was revealed that she had swallowed 6 mercuric cyanide tablets just prior to the onset of the illness. These 6 tablets contained a total of 36 grains of metallic mercury.

Administration of intravenous fluids to the production of beginning anasarca and paravertebral nerve block failed to stimulate urination. The bloody diarrhea ceased. Nausea and vomiting persisted, and after five days in the hospital (ten days after the onset of the illness) she was becoming comatose and exhibited fibrillary muscular twitchings. The blood urea nitrogen concentration was 95 mg. and blood creatinine 12.6 mg. per hundred cubic centimeters. The carbon dioxide combining power was 42 volumes per cent. During the five days only about 300 cc. of urine had been excreted, analysis of which revealed a specific gravity of 1.005, 4 plus albumin, and a urea nitrogen content of only 120 mg.

As the patient's condition had become critical and conservative therapeutic measures were of no avail, continuous peritoneal lavage in the manner described by Fine, Frank and Seligman[1] using Tyrode's solution was begun. Under local anesthesia an inflow tube and sump drain were inserted into the peritoneal cavity laterally at about the level of the umbilicus.

Perfusion of the peritoneal cavity with Tyrode's solution at the rate of 40 to 60 cc. per minute was begun. This solution contained per liter: NaCl, 8 Gm.; KCl, 0.2 Gm.; $CaCl_2$, 0.1 Gm.; $MgCl_2$, 0.1 Gm.; NaH_2PO_4, 0.05 Gm.; $NaHCO_3$, 1.0 Gm.; and dextrose, 2 Gm. Heparin, penicillin and streptomycin were added to the solution.

Just prior to entering the peritoneal cavity the fluid was heated to 40° C. Gravity promoted the flow through the inflow tube, and a small suction pump was attached to the sump drain.

A prompt fall in serum urea nitrogen and creatinine concentration occurred in twenty-four hours, and the patient was improved clinically.

On the third day of peritoneal lavage the blood creatinine concentration was one half as much as that at the beginning of the lavage. Anasarca was, however, becoming evident, and the carbon dioxide combining power was 22 volumes per cent.

The addition of dextrose sufficent to make the perfusion fluid a 10 per cent dextrose Tyrode's solution caused a rapid diminution of anasarca and permitted the intravenous administration of 1/6 molar sodium lactate solution in sufficient amount to correct the acidosis. At that time an appreciable urination was begun, and the azotemia rapidly diminished (fig. 1). The peritoneal tubes were removed and lavage discontinued after nine days, during which time 540 liters of solution had been perfused through the peritoneal cavity. For about one week after lavage was discontinued the patient had fever and some abdominal distention and tenderness. On the twenty-sixth hospital day and one month after ingestion of the mercuric cyanide she was discharged in good condition.

One month later urinalysis revealed a specific gravity of 1.014 and chemical and microscopic examinations gave negative results.

DISCUSSION

As apparently demonstrated by this reported instance of the use of peritoneal lavage, such a procedure is of value in the treatment of uremia. Unless, however, the etiology of the uremia is renal damage from which spontaneous recovery would be expected in a reasonable time, peritoneal dialysis could not be expected to be of practical

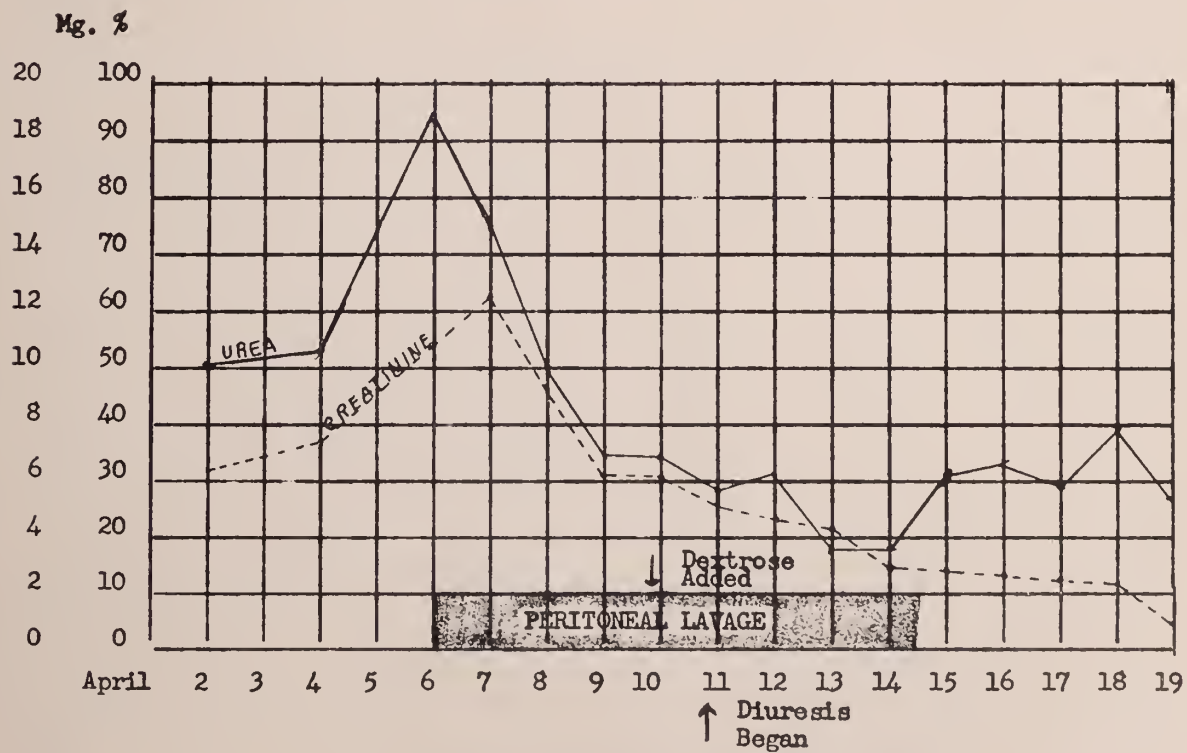


Figure 1

value. Acute renal damage from which the kidney usually recovers if given sufficient time occurs in heavy metal poisoning, intravascular hemolytic reactions (transfusion reactions, hemolytic anemias), sulfamido drug intoxications, burns and crushing injuries. In these conditions peritoneal lavage may be life-saving.

During the lavage, blood electrolyte and carbon dioxide combining power determinations should be made daily. Pathologic variations may be corrected by intravenous administrations or changes in the perfusing fluid concentrations.

In this instance a severe acidosis in the presence of beginning anasarca almost vitiated an otherwise excellent response. The acidosis was probably the result of excessive dilution and was remedied by the addition of dextrose to the perfusing solution sufficient to cause dehydration which then permitted the intravenous administration of 1/6 molar sodium lactate solution. The amount of dextrose added was, we believe, excessive and probably accounted for much of the abdominal discomfort and fever which occurred after discontinuing the lavage. Incidentally, when diuresis occurred after correction of the acidosis, the urine completely reduced Benedict's solution.

Clinical judgment would indicate the use of more conservative means of treating uremia of acute kidney damage first, but the patient should not be permitted to become moribund before instituting peritoneal lavage.

CONCLUSIONS

The treatment of azotemia due to acute renal failure by peritoneal lavage is of practical value.

Careful control of fluid and electrolyte balance and treatment of anemia and acidosis are necessary for successful peritoneal lavage. Changes in the perfusing fluid electrolyte concentrations may be required.

Peritoneal lavage may be indicated in the treatment of uremia of acute renal failure due to: (a) heavy metal poisoning, (b) intravascular hemolytic reactions, (c) sulfamido drug intoxication and (d) burns or crushing injuries.

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ABSTRACTS OF MEDICAL ARTICLES

DIFFUSE MALIGNANT MELANOMA OF THE IRIS: REPORT OF TWO CASES. By Shaler Richardson, M.D. Tr. Am. Ophth. Soc. 45:327-342, 1947.

In this article Dr. Richardson presents a comprehensive review of the subject of primary malignant melanoma of the iris, differentiating clearly the diffuse from the circumscribed type. After citing reports of 12 cases of the diffuse type, all that were discovered in a careful survey of the literature, he discusses nomenclature, age and sex incidence, etiology, pathology, diagnosis, prognosis and treatment. In its evolution the diffuse tumor, he observed, is distinguished from the circumscribed variety by its slow growth with long preservation of vision and lack of objective signs, its diffuse infiltration of the uveal tract and the extent of its metastatic spread. Once the diagnosis is established, enucleation without delay is advocated, but even this radical procedure at an early stage does not preclude metastases.

Two cases of this exceedingly rare lesion are reported. In one the tumor was of the epithelioid type and in the other the mixed cell type. In both the heavily pigmented tumor mass had spread diffusely throughout the iris, had invaded the ciliary body and had blocked the filtration angle. There was also glaucoma secondary to the tumor. The anterior chamber was, however, normal in depth, and vision was within normal limits. Reticulum content of approximately 50 per cent was demonstrated in both tumors.

Twenty-two months after enucleation in one case and three years in the other, there was no evidence of recurrence or metastasis. It is of interest that a pigmented spot or freckle on the iris of the affected eye was observed by one of the patients for some years prior to the development of the tumor.

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The Journal of The Florida Medical Association

Owned and published by Florida Medical Association, Inc.
P. O. Box 1018 (Fla. Theater Bldg.)
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DR. THAMES FLORIDA NOMINEE FOR AMA GENERAL PRACTITIONER AWARD

To Dr. Rufus Thames of Milton comes the high honor of being the Association's choice for the recipient of the 1948 General Practitioner's Award of the American Medical Association. This award is to be presented at the Interim Session in St. Louis this month. During the entire forty-two years of his medical lifetime Dr. Thames, who will be 74 years of age on December 14, has with unswerving fidelity and tireless zeal devoted his talents, skill and efforts to the service of the residents of the rural communities of Santa Rosa County in Northwest Florida.

Since this county has only three physicians, they are by invitation members of the Escambia County Medical Society. When informed that he was the unanimous choice of the society for the award, Dr. Thames, deeply moved, replied with characteristic modesty, "I have never done anything outstanding in my life. All I have ever done is just hard work, doing the best I could, which wasn't much. I am overcome by this action of my county medical society. I value and appreciate the respect of my fellow practitioners above anything else in the world. I wish I had the ability to express my gratitude to the members for this evidence of their good will."

A native of Burnt Corn, Ala., a small farming community, Dr. Thames attended the private country schools of the one room, one teacher variety prevalent in rural areas in the turbulent postwar period of the seventies and later. At an early age he began to earn his living by working on a farm. With his brother, he bought and operated a cotton gin and a small sawmill. When



DR. RUFUS THAMES

by thrift and hard work he had saved enough money to attend a medical school, he was nearly 30 years old. In 1906, he received the coveted degree of Doctor of Medicine from the Atlanta College of Physicians and Surgeons.

Dr. Thames then began the practice of medicine in Jay, a village in Santa Rosa County, and four years later he moved to Pace, a mill town in the same county. Since 1912 he has resided in Milton, but enjoys a wide practice throughout the county where he has spent more than four decades of medical service, practicing night and day, twelve months a year. He belonged first to the horse-and-buggy era, and in that rugged, unimproved section of the state not infrequently the horse alone could take him on his calls. In times of high water he crossed streams on boats or walked logs and continued on foot to see his patients. His was the third automobile to be brought to Santa Rosa County.

Across the years his practice has continued to take him to every community in the county, and it has always been his custom to answer calls without regard for monetary remuneration. He has delivered well over 3,000 babies, more than 50 of them within the last year, all in the home and in every nook and corner of the county. The range and type of service he renders his patients typifies the popular idea of what the ideal general practitioner should be.

By vocation a physician of highest caliber, "Dr. Rufe," as he is affectionately called, is by avocation a farmer. He raises cattle on the several farms he owns and supervises. Another interest in his drugstore. For recreational diversion he turns to fishing and hunting. His guns, ammunition and every known type of fishing tackle travel with him in his car, ready for a little use almost daily as he makes his country calls throughout a county crisscrossed by good fishing streams in good hunting ground.

Despite his strenuous twenty-four hour a day practice and his broad interests, this faithful servant of the people of an entire county drives the thirty miles to and from Pensacola with great regularity to attend county medical society and hospital staff meetings. His record of attendance is reported to be far better than the average for the local physicians. He also finds time to keep posted on the rapid advancements in his profession through his medical journals and frequent attendance on state and other medical meetings—his only vacations.

His keen sense of humor is by no means the least of the many attributes and traits which make this general practitioner adept in both the art and the technic of practicing medicine. Beloved by colleagues and laity alike highly commended for the award by service clubs and distinguished citizens of the state and county, he typifies the American way of life, and his medical career offers irrefutable evidence of the importance of the continuance of the practice of medicine as a private enterprise. Writes Governor Millard F. Caldwell of this country doctor: "During my residence at Milton Doctor Rufus Thames was not only my family physician but a warm friend and associate. His outstanding service as a doctor in his community for more than forty years would justify any honor that could be extended him. His service has been of the type that all too frequently is taken for granted and not properly recognized."

Since the selection of the recipient of the General Practitioner's Award now originates at the county level, annually each component county medical society will be urged to submit the name of a candidate for the outstanding general practitioner within the state, as all were asked to do this year. From the names submitted, the Board of Governors, by majority vote, chose Dr. Thames as the recipient of this honor, and he then became the Association's nominee for the national award. He thus is Florida's first nominee. Other candidates were Dr. Robert C. Woodard of Miami, nominated by the Dade County Medical Association; Dr. Isaac W. Chandler of Avon Park, nominated by the DeSoto-Hardee-Highlands-Charlotte-Glades County Medical Society; and Dr. Frederick F. Kumm of St. Petersburg, nominated by the Pinellas County Medical Society.

MEDICAL ETHICS

There are lofty policies which have served as the keystone for practitioners of the healing art since the days of Hippocrates. Most physicians take pride in the principles laid down in the Hippocratic Oath and do not deviate therefrom because those principles are fundamentally sound.

There are, however, many specific rules of conduct outlined in the American Medical Association's Principle of Medical Ethics which appear to need sharp revision and modernization. These principles of medical ethics apparently were drawn up about a century ago and have undergone no major revision since 1880.

Those rules relating to the requirement of formal dismissal of a previous physician no matter how long it has been since he has served the patient, social calls upon a friend under another physician's care, circulation of professional cards, and the bizarre formalities which a consultant should follow, such as delivering his opinion in writing and under seal to the physician in charge—all of these, it would seem, are in line for intelligent change and revision.

On the other hand, those rules which require that a physician should be "upright, pure, diligent, conscientious, modest, sober, prompt, pious" are excellent. If he is all of these, he will need to refer to no code, ancient or modern. His actions will model the code.

From the practical point of view, few can measure up to these ideals, but they are something to shoot for. The physician who practices the golden rule seldom will need an ethical guidebook.

YEAR'S END MEDITATION THE AMERICAN HERITAGE

Year's end again. The Yuletide and then another New Year. It is the time of year to take stock.

The world's uneasy peace remains far from all that was desired and hoped for at the beginning of this year, and America's stellar role in world affairs places tremendous responsibility on this great nation down to the last citizen who truly lays claim to being an American. What makes America great? Not the vastness of its tangible assets—instead, the host of intangibles that are its heart and soul and life's blood. No two persons would describe them alike, or perhaps find words, however inspiring, to describe them at all, for they reach to the roots of the personal experience and the living of each and every individual American and find expression in the distinctly American way of life.

Recently, on the occasion of his seventy-fourth birthday, one who has lived many kinds of American life—boy in an Iowa village, ward of a country doctor in Oregon, university student, engineer, president of the United States—spoke out of the wealth of his experience on the meaning of America. Said Herbert Hoover:

> I have seen America in contrast with many nations and races . . . I have worked in governments of free men, of tyrannies, of Socialists and of Communists. I have met with princes, kings, despots and desperados.
>
> I have seen the squalor of Asia, the frozen class barriers of Europe . . . And outstanding everywhere to these great masses of people there was a hallowed word—"America." To them, it was the hope of the world.
>
> My every frequent homecoming was a re-affirmation of the glory of America. Each time my soul was washed by the relief from grinding poverty of other nations, by the greater kindliness and frankness which comes from acceptance of equality and the wide-open opportunity to all who want a chance. It is more than that. It is a land of self-respect born alone of free men . . .
>
> The meaning of our word "America" flows from one pure spring. The soul of our America is its freedom of mind and spirit in man. Here alone are the open windows through which pours the sunlight of the human spirit. Here alone is human dignity not a dream, but an accomplishment . . .
>
> There are today fuzzy-minded people in our country who would compromise in these fundamental concepts. They scoff at these tested qualities in men. They never have understood and never will understand what the word *America* means . . . This new land with all its high promise cannot and will not be conquered except by men inspired from the concepts of free spirit.
>
> It is those moral and spiritual qualities in free men which fulfill the meaning of the word *American*. And with them will come centuries of further greatness to our country.

Every member of the Association, as he exchanges the season's greetings this December with his patients and his friends, should be mindful that the medical profession is in the vanguard of attack from subversive elements that would rob him and his fellow citizens of those inalienable rights and special attributes which characterize Americans. Let us be alert and more on guard than ever in 1949, lest we stand by to see not only professional freedom but the very land of freedom, the America we know and love, destroyed before our very eyes.

HIGH DEATH TOLL FROM ACCIDENTS AMONG PRESCHOOL CHILDREN

To the lives of American children of preschool age accidents are the greatest single menace. Some five thousand children of ages 1 to 4 die annually as a result of accidents, and these deaths comprise approximately one fourth of the deaths from all causes combined among these children.

A recent analysis[1] of 775 fatalities occurring during 1946 and 1947 among children insured by the Metropolitan Life Insurance Company revealed that fatal mishaps come to tots of this age group under a wide variety of circumstances, ranging from a fall on the floor at home to the crash of a seaplane into a lake. Two main classes of injury, however, accounted for nearly two thirds of these accidental deaths; accidents involving motor vehicles were responsible for

34 per cent, and burns, conflagrations, or explosions accounted for an additional 27 per cent. Next in order of frequency were drownings with 13 per cent, falls with 6 per cent and poisonings with 5 per cent. These rankings reflect essentially the experience among the boys, who accounted for more than three fifths of all the deaths. Burns and conflagrations were the leading cause of accidental death among the girls, with motor vehicle accidents a close second.

Nearly twice as many boys as girls were run over or hit by an automobile. A large percentage of motor vehicle accidents occurred right around the children's own homes, some in their own yard or driveway. A number were killed by a parent or some other member of the family, and in other instances a deliveryman was responsible.

More than half of the 213 children in this series who died from burns, conflagrations or explosions were trapped in burning buildings. Of the 99 who lost their lives because of burns or scalds, exclusive of conflagration, 56 upset hot fluids or fell into them.

Out of the 100 children who were victims of drowning, 80 were boys. A considerable number of these fatalities took place in and around the home. Well over half of these children were drowned in creeks, brooks, rivers and other bodies of water; 7 per cent lost their lives in fishponds, and a somewhat higher proportion died in cisterns, septic tanks and the like.

Falls accounted for 50 of these fatal injuries. No particular type was outstanding, though falls from windows claimed 11 lives and from porches 6 victims. Accidental poisonings proved fatal to 28 boys and 11 girls, oil of wintergreen claiming 8 lives, and kerosene, gasoline and cleaning fluids 6 lives. Choking was by no means rare. There were 26 children in this series who died from the aspiration or swallowing of objects, which consisted of some form of food, such as peanuts or bread, in nearly half of the cases. Accidents with firearms and the absorption of poisonous gas each took 12 lives.

This study emphasizes what common experience suggests, that children of preschool age heedlessly venture wherever they can and too often let their curiosity lead them to destruction. From the time they begin to move about on their own until they are off to school, safety of life and limb for them depends upon the constant vigilance, the ever watchful eye of their elders.

1. High Accident Death Toll Among Preschool Children. Statistical Bulletin, Metropolitan Life Insurance Company. 29:1-4 (June) 1948.

AMERICAN MEDICAL WRITERS' ASSOCIATION

The American Medical Writers' Association, devoted to the improvement of the written word of medicine, came into being on Sept. 29, 1948 at a meeting in Springfield, Ill. It is a continuation, with an expanded program, of the Mississippi Valley Medical Editors' Association, organized in 1940, and the Mississippi Valley Medical Journal serves as its official publication.

The purpose of this organization is defined as "(a) to bring into one organization all physicians interested in medical journalism or medical writing, and all laymen who are connected with the editorial or business staff of medical periodicals, libraries, foundations, or publishing companies; (b) to help improve medical literature; (c) to secure interchange of views of the members so that they may attain such intelligent unity and harmony in every phase of their labor as will elevate and make effective the opinions of the medical profession in their respective communities."

All members are to be active members, but nonmedical members must be college graduates and must be sponsored by an active physician-member of the association. Membership fees and dues to Jan. 1, 1950 are $5.00, and thereafter the annual dues will be $3.00. Membership application blanks may be obtained from the secretary, Dr. Harold Swanberg, 209-224 W. C. U. Building, Quincy, Ill. A membership booklet will be published in February.

The Sixth Annual Meeting will be held at the Jefferson Hotel in St. Louis on Sept. 28, 1949. For that meeting the presentation of papers and a course in medical writing are being planned.

PHYSICIANS WARNED OF DANGEROUS PROCAINE HYDROCHLORIDE SOLUTION

The Food and Drug Administration of the Federal Security Agency issued on Oct. 8, 1948 a warning to physicians that certain codes of procaine hydrochloride solution manufactured by the C. B. Kendall Company of Indianapolis, Ind., are dangerous and should not be used inasmuch as they "caused severe necrotic damage upon injection." The codes specified are 24830 and 64712.

The manufacturer, following reports of untoward reactions from a batch of the solution coded 24830 and placed in distribution in Feb-

ruary 1948, determined that the solution is highly acid, possessing a hydrogen ion concentration of about 1. The company's recall program has not been completely effective. The hydrogen ion concentration of a vial of the lot coded 64712 was found to be 2.9. These two products have been distributed in the area from Florida to Wisconsin and from West Virginia to Texas.

Several other lots of injection drugs possessing a hydrogen ion concentration of 3.0 or less have been distributed by the C. B. Kendall Company. Of these, the firm voluntarily recalled the following products on which complaints were received: Vitamin B Complex Stronger, Lot No. 54843; Vitamin B Complex, Lot No. 44832; Pentabexin, Lot Nos. 44823 and 54837; and Thiadoxin, Lot Nos. 34808, 44817 and 64842.

Also, the following injection products of this firm have shown low hydrogen ion concentration values as indicated:

Product	Lot Number	pH
Vitamin B Complex Stronger	64844	2.9
Vitamin B Complex	54811	2.8
Thiamine Hydrochloride	34817	2.6
Thiamine Hydrochloride	74806	2.9
Pyridoxine Hydrochloride	74725	2.7
Pentabexin	64812	3.0
Procaine Hydrochloride	74871	3.0

THE ARTHRITIS AND RHEUMATISM FOUNDATION

Seven and one-half million persons in the United States suffer from arthritis or related disorders. They and the thirty million members of their families are watching hopefully the unity of effort that has been effected through the recently organized Arthritis and Rheumatism Foundation. Leaders in industry, philanthropy and medical science whose names carry confidence comprise the new organization's board of directors. The Foundation is planned along the lines of similar groups such as the National Foundation for Infantile Paralysis, the American Cancer Society and the American Heart Association and will function in a similar manner.

To guide the medical policies and activities in the attack on one of the major problems facing the medical profession, ten nationally known physicians and scientists have been appointed to the Medical and Scientific Committee. Functions of this committee will include the development of programs to be undertaken by the thirty-eight local chapters of the Foundation which are being organized throughout the country and advising the chapters in carrying them out. The committee will establish and promote medical standards, particularly with regard to rheumatism clinics, and will also establish standards and goals for medical education in the field of rheumatism on such levels as undergraduate medical education, graduate education aimed at proficiency in clinical care, and suggested plans for rheumatism education programs for the general practitioner, to be carried out by chapters in cooperation with state and county medical societies.

Among the main objectives of the Foundation are the making of a nationwide survey of the problem, arousing the public and the medical profession to the need for action, fostering research, establishing fellowships and providing improved care for persons with rheumatic diseases.

As the Foundation launches its initial public program, it bespeaks the interest and the backing of every physician. Its objectives, its sponsors and its approach to the problem merit the support of the medical profession and the public.

YOUR BLUE SHIELD PLAN

At this time there are 1,396 Florida doctors participating in the Florida Blue Shield Plan. Participation in the plan does not mean only the rendering of services according to the terms of the agreement. That, of course, is the primary concern. However, Webster defines the word "participate" as follows: "To have a share in common with others," and no definition could be more appropriately used to describe the physicians' part in the Blue Shield Plan.

Blue Shield is the physicians' own plan—organized and governed by them. The growth and success of the plan depend upon them. To truly participate in the plan, the doctor should have a complete understanding and belief in the Blue Shield movement and what it stands for—the American way of furnishing adequate, low cost medical care for the people. Physicians should become interested in the growth and development of their plan, and actively assist in these endeavors (1) by urging *all* physicians, not surgeons only, to participate in the plan, and (2) by educating patients as much as possible to Blue Shield.

In reference to the first point mentioned, it is true that the plan now covers only surgical procedures, fractures and maternity care, and it

might seem unnecessary for physicians other than surgeons to participate; however, all doctors should realize the importance of participating in the doctors' own plan. Their names alone, included in the list of participating physicians, add prestige to the plan and thereby tend to increase membership, which will ultimately result in a wider range of benefits including medical, as well as surgical care. In reference to the second item, the physician should make it a point to be well informed on Blue Shield in order that he may pass on this information to his patients, which, again, will result in increased enrolment and increased benefits.

Another way in which the doctor may actively participate in the Blue Shield Plan is to serve as an Active Member of the Corporation, for which all participating physicians are eligible. Nominations for election to the Board of Directors of the Blue Shield Plan are made by the Florida Medical Association from the list of Active Members, and elections are held annually at the meeting of the Active Membership. A better understanding and appreciation of the problems with which Blue Shield is confronted should be had by all participating doctors, and there is no better way to obtain this knowledge than by attending the annual meeting of Active Members. Applications for Active Membership may be obtained from the home office of the plan in Jacksonville.

The plan is still in its formative years. As experience is gained, changes will be made and benefits broadened for both the physician and the patient. Since the plan is still young, mistakes will undoubtedly be made and physicians are asked to bear with the plan, not oppose it. Physicians are free at all times to voice their opinions to the plan, and all suggestions are given careful attention and consideration.

With the support and cooperation of all physicians, a movement as great as Blue Shield cannot help but succeed.

RESERVE THESE DATES
APRIL 10, 11, 12, 13, 1949
FOR THE CONVENTION IN
BELLEAIR

MEETINGS OF MEDICAL DISTRICTS

At the four medical district meetings held in October, members of the Association were provided excellent programs consisting of well prepared and well presented scientific papers, personal messages from the officers of the Association and appropriate entertainment. The brevity and conciseness of these one-day meetings enable many physicians throughout the state to meet their officers and associates and at the same time to hear papers of scientific value.

Dr. Herman Watson, chairman of Council, the eight councilors, secretaries and committees of the host county medical societies, essayists and Association officers are to be commended on their efforts to make the meeting successful.

All state officers whose names were listed on the printed program appeared at each of the four medical district meetings and discussed subjects of interest to the entire membership. Considerable time and expense were required to reach the four corners of the state in one week and not a single officer missed his appointment. The members present expressed sincere appreciation to the officers who in this way gave evidence of their interest and faithfulness in the affairs of the Association.

Dr. Joseph S. Stewart, president, discussed the Blue Cross and the Blue Shield and their relation to socialized medicine. Dr. Stewart explained that both plans are of vital interest to every member. The development of them was undertaken voluntarily and recommended by the House of Delegates.

Dr. Walter C. Payne, president-elect, discussed the purpose and activities of the Florida Academy of Public Medicine. Dr. Payne explained that the purpose of this academy is to promote the Association's public relations program. The office of the academy adjoins the Association's offices on the fourth floor of the Florida Theatre Building, Jacksonville.

Dr. Robert B. McIver, secretary-treasurer, reviewed plans evolving from a resolution of the last meeting of the House of Delegates in connection with proposed scientific sections at the Association's annual meeting. A small committee was appointed by the Board of Governors and this committee spent a Sunday preparing a plan which was later presented at a meeting of the Board of Governors and adopted on a trial basis. At the Seventy-Fifth Annual Meeting at Belleair next April, specialty groups will meet on

Sunday just preceding the annual convention. Thirteen specialty groups have arranged Sunday meetings. There will be five scientific assemblies which will make it possible to have more than twenty papers presented. Each specialty group has been invited to furnish an essayist for one of the scientific assemblies. This plan will provide papers of general interest from the specialty groups, and, at the same time, make provision for sufficient time in the scientific assemblies for as many papers from the membership at large as were used at last year's meeting. So far, the new arrangement has met with unanimous approval.

Dr. Webster Merritt, assistant editor of The Journal, described in detail the various sections of your Journal. He made a plea for papers containing new or original material, commentaries, news items and constructive criticisms. He repeated what has ofttimes been said in the presence of the members, "It is your Journal and will be just as good as you make it." Sheets of paper were passed to the members present, and he requested answers to three questions. The answers were not to be signed but to be used as an index to the reading of The Journal, the section of most interest, and so forth. When these answers are tabulated they should give a cross section on the relation of The Journal to the membership which receives it. Dr. Merritt paid special tribute to Dr. Shaler Richardson, editor of The Journal, who has served more than twenty years and was unable to be present because he was required to attend a medical meeting elsewhere.

Dr. Duncan T. McEwan, chairman of the Board of Governors, being the last speaker, was not held down to a specific subject. He enlarged on some of the high points brought out by previous speakers and reviewed some of the problems and decisions facing the Board of Governors at the regular meetings. At the request of Dr. Chas. J. Collins, chairman of the Committee on Scientific Work, Dr. McEwan urged every member who wishes to present a paper at the annual meeting at Belleair next April to send in his application and a fifty-word synopsis without delay. This committee will meet the first of December and the entire program will be completed at that time.

No effort was made to reproduce the addresses of the officers in this article as they are, for the most part, progress reports. Completed manuscripts will appear in the Proceedings Number of The Journal at the end of the year.

The total registration for the four medical district meetings was 333. Of this number, 215 were Association members, 53 were visitors and 65 were ladies.

Eight scientific papers were presented at the meetings. These papers are scheduled to appear in The Journal for the benefit of the entire membership.

NORTHWEST MEDICAL DISTRICT—A OCTOBER 18—LIVE OAK

At the scientific assembly and the general session, Dr. Herman Watson and Dr. Irby H. Black, councilor of district 2, presided at the meeting which was held at the Suwannee County Country Club.

At 2:30 p.m., Dr. C. LeRoy Adams, Jr., president of the Madison-Suwannee County Medical Society, welcomed the members and guests.

Dr. Thomas H. Bates of Lake City, a member of the district, spoke on "Saddle Block Analgesia for Obstetrics." Dr. S. L. Watson, Jr., of Lakeland, the guest speaker, chose for his subject, "A Plan of Conservative Management of Antepartum Eclampsia." A general discussion followed the reading of the papers.

Quincy was selected at the general session for the meeting place in 1949 at the invitation of Dr. F. Erwin Daves, representing the Leon-Gadsden-Liberty-Wakulla-Jefferson County Medical Society.

Dr. Watson called on the officers of the State Association who responded with addresses of unusual interest.

Refreshments were served by the host society.

Dr. Robert B. Harkness of Lake City was the toastmaster at the dinner which was served at 6:30 p.m.

The total registration was 53, of which number 28 were Association members (from A district, 16), 20 were visitors and 5 were ladies. State Association officers present were: Joseph S. Stewart, president; Walter C. Payne, president-elect; Robert B. McIver, secretary-treasurer; Webster Merritt, assistant editor of The Journal; Duncan T. McEwan, chairman of the Board of Governors; Stewart G. Thompson, managing director; Herman Watson, chairman of Council; Irby H. Black, councilor of district 2.

REGISTRATION

FOLEY: Walter J. Baker. JACKSONVILLE: Luther W. Holloway, James G. Lyerly, Robert B. McIver, Webster Merritt, Roger F. Sondag, Wilson T. Sowder, Stewart G. Thompson. LAKE CITY: Laurie J. Arnold, Jr., Thomas H. Bates, Robert B. Harkness, James F. Pitman. LAKELAND: Herman Watson, S. L. Watson, Jr. LIVE OAK: C. LeRoy Adams, Jr., Irby H. Black, Joshua M. Price, John N. Sims, J. Dillard Workman. MARIANNA: Francis M. Watson, Courtland D. Whitaker. MIAMI: Joseph S. Stewart. ORLANDO: Duncan T. McEwan. PENSACOLA: Walter C. Payne. PORT ST. JOE: Albert L. Ward. TALLAHASSEE: Merritt R. Clements, George H. Garmany. TAMPA: Oren A. Ellingson.

VISITING DOCTORS—JACKSONVILLE: Edw. J. Sullivan. LAKE CITY: Joseph Abrams, Samuel L. Aspin, Albert M. Deal, Paul E. Gutman, Louis G. Landrum, J. M. Lee, Louis M. Sales, Eugene H. Silverstone, Clifton G. York. LIVE OAK: E. H. John. MADISON: Julian M. DuRant, Wallace E. Winter. MARIANNA: Albert E. McQuagge. WHITE SPRINGS: Ross A. Barnett.

OTHER GUESTS—JACKSONVILLE: Mr. Ernest R. Gibson, Mr. John W. Herbert, Mr. H. A. Schroder. LAKE CITY: Mr. Gilbert Cook, Mr. O. E. Herndon.

LADIES—LIVE OAK: Mrs. C. LeRoy Adams, Jr., Mrs. Irby H. Black, Mrs. John N. Sims. MADISON: Mrs. Julian M. DuRant, Mrs. A. Franklin Harrison.

NORTHEAST MEDICAL DISTRICT—B
OCTOBER 19—DAYTONA BEACH

The meeting was held at the Ocean Dunes Club with Dr. Herman Watson, chairman of Council, presiding at both the scientific assembly and the general session.

At 2:30 p.m., members and guests were welcomed by Dr. Charles E. Tribble, president of the Volusia County Medical Society.

The scientific program was opened by Dr. E. Frank McCall of Jacksonville, a district member, who presented a paper on "The Toxemias of Pregnancy." The speaker by invitation, Dr. Herschel G. Cole of Tampa, presented a paper on "Fractures of Neck and Femur." The floor was opened for discussion of the papers.

At the general session, Palatka was selected as the meeting place for 1949. The invitation was extended by Dr. Grover C. Collins in behalf of the Putnam County Medical Society.

The chairman called on the officers of the State Association who responded with addresses of unusual interest.

Refreshments and dinner were served by the host society.

The total registration was 99, of which 66 were Association members (from B district, 60), 11 were visitors and 22 were ladies. State Association officers present were: Joseph S. Stewart, president; Walter C. Payne, president-elect; Horace A. Day, second vice president; Reddin Britt, third vice president; Robert B. McIver, secretary-treasurer; Webster Merritt, assistant editor of The Journal; Duncan T. McEwan, chairman of the Board of Governors; Stewart G. Thompson, managing director; Herman Watson, chairman of Council.

REGISTRATION

COCOA: Thomas C. Kenaston. CRESCENT CITY: Edward W. Ford, Bernard E. Kane. DAYTONA BEACH: John D. Browning, Cleland D. Cochrane, C. Robert DeArmas, George M. Green, Harry Hausman, William L. Jennings, Eric H. Lenholt, Leon S. Lippincott, Robert L. Miller, Achille A. Monaco, Joseph H. Rutter, Charles O. Sayres, Stanford S. Setnor, Vaughan A. Shaw, James R. West, Norman E. Williams. DeLAND: Charles E. Tribble. GAINESVILLE: Edwin H. Andrews, Henry J. Babers, Jr., Harry M. Merchant, George H. Putnam, Thomas A. Snow. GRANDIN: James W. Brantley.

JACKSONVILLE: Karl B. Hanson, Louie Limbaugh, James G. Lyerly, Banks H. Goodale, Edward Jelks, E. Frank McCall, Robert B. McIver, Webster Merritt, Roger F. Sondag, Wilson T. Sowder, Stewart G. Thompson, Ashbel C. Williams. Lakeland: Herman Watson, S. L. Watson, Jr. LEESBURG: Marion B. O'Kelley. MELBOURNE: Theodore J. Kaminski, Arthur C. Tedford. MIAMI: Joseph S. Stewart. OCALA: Eugene G. Peek, Eugene G. Peek, Jr.

ORLANDO: Chas. J. Collins, Horace A. Day, George W. Edwards, II, Hewitt Johnston, Duncan T. McEwan, Meredith Mallory, Fred Mathers, Louis M. Orr, II, Louis E. Pohlman, W. Dean Seward, Robert E. Zellner. PALATKA: Grover C. Collins. PENSACOLA: Walter C. Payne. ST. AUGUSTINE: Reddin Britt, Hardgrove S. Norris. SANFORD: Wade H. Garner, Thomas F. McDaniel, Harry Z. Silsby. TAMPA: Herschel G. Cole, Elbert J. Soskis.

VISITING DOCTORS—DAYTONA BEACH: David W. Goddard, F. F. Tucker. GAINESVILLE: Henry H. Graham. Winston L. Summerlin. JACKSONVILLE: Malcolm J. Ford, Vernon T. Grizzard, Jr., Walter P. Keith. ORLANDO: Paul H. Jenkins.

OTHER GUESTS—JACKSONVILLE: Mr. Ernest R. Gibson, Mr. John W. Herbert, Mr. H. A. Schroder.

LADIES—DAYTONA BEACH: Mrs. Cleland D. Cochrane, Mrs. C. Robert DeArmas, Mrs. David W. Goddard, Mrs. George M. Green, Mrs. William L. Jennings, Mrs. Eric H. Lenholt, Mrs. Robert L. Miller, Mrs. Vaughan A. Shaw, Mrs. Ludo von Meysenbug, Mrs. Norman E. Williams. GAINESVILLE: Mrs. Henry J. Babers, Jr., Mrs. Henry H. Graham, Mrs. George H. Putnam, Mrs. Winston L. Summerlin. JACKSONVILLE: Mrs. Edward Jelks, Mrs. E. Frank McCall. OCALA: Mrs. Eugene G. Peek, Jr. ORLANDO: Mrs. George W. Edwards, II, Mrs. Paul H. Jenkins. PALATKA: Mrs. Grover C. Collins. SANFORD: Mrs. Thomas F. McDaniel, Mrs. Harry Z. Silsby.

SOUTHWEST MEDICAL DISTRICT—C
OCTOBER 20—BRADENTON-SARASOTA

The meeting was held at the Sarasota Bay Country Club, six miles south of Bradenton, with Dr. Herman Watson, chairman of the Council, presiding at the scientific assembly and the general session. Dr. H. Quillian Jones, councilor of district 6, and Dr. John M. Butcher, councilor of district 5, also were presiding officers.

Dr. Millard P. Quillian, president of the Manatee County Medical Society, and Dr. Butcher, president of the Sarasota County Medical Society, welcomed the members and guests.

"A Type of Anesthesia in Herniorrhaphy with

Reference to the Aged" was chosen by district member, Dr. Joseph L. Selden, Jr., of Ft. Myers as the initial paper of the scientific program. Dr. David R. Murphey, Jr., of Tampa spoke on "State Blood Bank Program." Interesting discussions followed.

At the general session, Sebring was selected as the meeting place in 1949. The invitation was extended by Dr. Leldon W. Martin in behalf of the DeSoto-Hardee-Highlands-Charlotte-Glades County Medical Society.

The chairman called on the officers of the State Association who responded with addresses of unusual interest.

Refreshments were served by the host societies.

Dr. Joseph Halton of Sarasota was the toastmaster at the dinner which was served at 6:30 p.m.

The total registration was 129, of which 84 were Association members (from C district, 76), 13 were visitors and 32 were ladies. State Association officers present were: Joseph S. Stewart, president; Walter C. Payne, president-elect; Robert B. McIver, secretary-treasurer; Webster Merritt, assistant editor of The Journal; Duncan T. McEwan, chairman of the Board of Governors; Stewart G. Thompson, managing director; Herman Watson, chairman of Council; H. Quillian Jones, councilor of district 6; John M. Butcher, councilor of district 5.

REGISTRATION

ARCADIA: Charles H. Kirkpatrick, John A. Simmons. BARTOW: Chester H. Murphy. BRADENTON: William F. Bay, Lowrie W. Blake, Alva J. Floyd, Willis W. Harris, M. M. Harrison, Roderic O. Jones, Paul K. Keller, Chas. W. Larrabee, Millard P. Quillian, William D. Sugg, Willett E. Wentzel. CLEARWATER: William G. Mason. DUNEDIN: John A. Mease, Jr., Walter H. Winchester. FT. MYERS: Joseph D. Brown, Angus D. Grace, William H. Grace, H. Quillian Jones, Joseph L. Selden, Jr. JACKSONVILLE: Robert B. McIver, Webster Merritt, Lorenzo L. Parks, Wilson T. Sowder, Stewart G. Thompson.

LAKELAND: Jere W. Annis, James R. Boulware, Jr., Samuel J. Clark, Herman Watson, S. L. Watson, Jr. MANATEE: Blake M. Lancaster. MIAMI: Joseph S. Stewart. MULBERRY: Milo H. Holden. ORLANDO: Duncan T. McEwan. PALMETTO: Joseph A. Gibson. PENSACOLA: Walter C. Payne. ST. PETERSBURG: George H. Anderson, Howard H. Curd, Woodrow B. Estes, John P. Ferrell, N. W. Gable, Abraham J. Gorday, James L. Gouaux, Henry J. Jensen, Whitman C. McConnell, Whitman H. McConnell, Roderick C. Webb, Kenneth J. Weiler. SARASOTA: Lester H. Blackburn, Blanche A. Burgner, John M. Butcher, Joseph Halton, J. Edward Harris, Stanley T. Martin, A. Lamar Matthews, Jr., Edward F. Meares, A. George Meister, Arthur O. Morton, Henry G. Morton, John C. Patterson, Hugh G. Reaves, Theodore M. Trousdale, Henry J. Vomacka, Millard B. White, Reaves A. Wilson.

SEBRING: Leldon W. Martin. TAMPA: Chadbourne A. Andrews, William C. Blake, J. Robert Campbell, Harold Carron, Frank V. Chappell, Eugene S. Gilmer, Charles McC. Gray, Charles E. Hebard, Linus W. Hewit, Frank C. Metzger, David R. Murphey, Jr., Elbert J. Soskis, Morris Waisman, Wesley W. Wilson. VENICE: Talmadge S. Thompson. WINTER HAVEN: Lee E. Parmley.

VISITING DOCTORS—BAY PINES: E. F. Dougherty, R. D. Hawthorne. BRADENTON: John E. Granade. DUNEDIN: E. F. Kitzmiller. MANATEE: S. J. Hillis. SARASOTA: Thomas C. Garrett, P. F. Holm, Karl R. Rolls, W. A. Shannon. TAMPA: Ernest R. Bourkard.

OTHER GUESTS—JACKSONVILLE: Mr. Ernest R. Gibson, Mr. John W. Herbert. ST. PETERSBURG: Mr. W. A. Zerbe

LADIES—BRADENTON: Mrs. John E. Granade, Mrs. M. M. Harrison, Mrs. Roderic O. Jones, Mrs. Willett E. Wentzel, Mrs. Millard B. White. CLEARWATER: Mrs. William G. Mason. FT. MYERS: Mrs. Angus D. Grace, Mrs. H. Quillian Jones, Mrs. Joseph L. Selden, Jr. MANATEE: Mrs. S. J. Hillis. ST. PETERSBURG: Mrs. George H. Anderson, Mrs. Howard H. Curd, Mrs. John P. Ferrell, Mrs. N. Worth Gable, Mrs. Whitman C. McConnell, Mrs. Whitman H. McConnell.

SARASOTA: Mrs. Thomas C. Garrett, Mrs. Joseph Halton, Mrs. Stanley T. Martin, Mrs. A. Lamar Matthews, Jr., Mrs. Cecil E. Miller, Mrs. Arthur O. Morton, Mrs. Henry G. Morton, Mrs. John C. Patterson, Mrs. W. A. Shannon, Mrs. Henry J. Vomacka, Mrs. Reaves A. Wilson. SEBRING: Mrs. Leldon W. Martin. TAMPA: Mrs. Harold Carron, Mrs. Linus W. Hewit, Mrs. David R. Murphey, Jr. VENICE: Mrs. Talmadge S. Thompson.

SOUTHEAST MEDICAL DISTRICT—D
OCTOBER 22—WEST PALM BEACH

Dr. Russell B. Carson, councilor of district 8, and Dr. Erasmus B. Hardee, councilor of district 7, presided at the scientific assembly and the general session of the meeting which was held at the Flotilla Club.

Dr. Victor Clarholm, president of the Palm Beach County Medical Society, welcomed the members and guests.

Dr. Scottie J. Wilson of Ft. Lauderdale, a member of the district, opened the scientific program with his paper on "Practical Considerations Concerning Management of Nephritis." Dr. J. Brown Farrior of Tampa, the speaker by invitation, read a paper on "Total Laryngectomy." Discussions followed.

At the general session, Ft. Lauderdale was designated as the meeting place in 1949. The invitation was extended by Dr. Carson in behalf of the Broward County Medical Society.

The chairman called on the officers of the State Association who responded with addresses of unusual interest.

Refreshments and dinner were served by the host society.

The total registration was 52, of which 37 were Association members (from D district, 29), 9 were visitors and 6 were ladies. State Association officers present were: Joseph S. Stewart, president; Walter C. Payne, president-elect;

Robert B. McIver, secretary-treasurer; Duncan T. McEwan, chairman of the Board of Governors; Stewart G. Thompson, managing director; Russell B. Carson, councilor of district 8; Erasmus B. Hardee, councilor of district 7.

REGISTRATION

FT. LANDERDALE: Russell B. Carson, Anna A. Darrow, Burns A. Dobbins, Jr., Scottie J. Wilson. JACKSONVILLE: Robert B. McIver, Webster Merritt, Roger F. Sondag, Wilson T. Sowder, Stewart G. Thompson. JUPITER: James C. Nowling. LAKE WORTH: A. Scott Turk. MIAMI: Joseph S. Stewart. ORLANDO: Duncan T. McEwan. PALM BEACH: Alvin E. Murphy, Bailey B. Sory, Jr., William B. Wilkins. PENSACOLA: Walter C. Payne. TAMPA: J. Brown Farrior.

VERO BEACH: Erasmus B. Hardee, P. T. McClellan. WEST PALM BEACH: Mark M. Byrd, James L. Carlisle, Victor Clarholm, C. Jennings Derrick, Gerald M. DeWoody, Charles McD. Harris, Jr., Frederick K. Herpel, Russell D. D. Hoover, Lorenzo James, Jr., Oliver L. Jones, David W. Martin, Lloyd J. Netto, Ralph M. Overstreet, Jr., Cecil M. Peek, Laurie R. Teasdale, Wm. E. Van Landingham, William H. Weems.

VISITING DOCTORS—FT. LAUDERDALE: Raymond M. Price. MELBOURNE: J. F. Henry. WEST PALM BEACH: J. Robert Andrews, Burton F. Austin, Walter R. Newbern, Theodore Norley, Raymond S. Roy.

OTHER GUESTS—JACKSONVILLE: Mr. Ernest R. Gibson, Mr. John W. Herbert.

LADIES—FT. LAUDERDALE: Mrs. Zola Brown. Mrs. Russell B. Carson, Mrs. Raymond S. Roy. WEST PALM BEACH: Mrs. David W. Martin, Mrs. Lloyd J. Netto, Mrs. Walter R. Newbern.

BIRTHS AND DEATHS

BIRTHS

Dr. and Mrs. Max Suter, Jacksonville, announce the birth of a son, Max Murrhee, on Oct. 14, 1948.

Dr. and Mrs. Henry B. Dickens, Jr., Fernandina, announce the birth of twin sons, Henry Bailey, III, and Herbert Victor, on Sept. 27, 1948.

Dr. and Mrs. Paul H. Martin, Jacksonville, announce the birth of a daughter on Oct. 1, 1948.

DEATHS—MEMBERS

Dr. Edw. Meadow, Miami ... Oct. 10, 1948

DEATHS—OTHER DOCTORS

Dr. James G. Thames, Milton ... Oct. 2, 1948
Dr. James C. Spell, Titusville ... Sept. 16, 1948
Dr. Horace G. Smithy, Jr., Roper Hospital, Charleston, S. C. ... Oct. 28, 1948
Dr. George W. Wood, Oxford ... Nov. 2, 1948

SACRIFICE for quick sale to settle estate, complete medical office including Hamilton Steeltone treatment room, Westinghouse fluoroscope and G. E. portable x-ray, Jones B. M. R. machine and other necessary supplies and equipment all in A-1 condition. Office space of three large rooms partitioned into five-room workable suite. Lease available. Central Florida. Write 69-20, P. O. Box 1018, Jacksonville, Fla.

STATE NEWS ITEMS

The Florida State Pediatric Association held its Fall meeting at the Angebilt Hotel in Orlando on October 9 and 10. Thirty-five members and approximately twenty guests were present. Dr. Edgar W. Stephens, Jr., of West Palm Beach, president of the association, conducted the business meeting.

The guest speaker, Dr. Robert Lawson of the Bowman-Gray School of Medicine at Winston-Salem, N. C., spoke on the treatment of meningitis and certain phases of poliomyelitis based on experiences with the recent outbreak of the disease in North Carolina.

Drs. Orion O. Feaster and Annette M. Feaster, formerly of St. Petersburg, are now living in Tacoma, Wash., Route 10, Box 129. Dr. Feaster writes that he has returned to active duty with the United States Army Medical Corps and probably will be stationed for some time at Madigan General Hospital.

Dr. Sidney Davidson of Lake Worth completed a course in electrocardiography at the University of Michigan in the early fall. While in the North, he toured through New York.

Dr. Leroy H. Oetjen of Leesburg was the guest speaker at the local Kiwanis Club luncheon in September. Dr. Oetjen's address was on "Cancer Research and Control."

Dr. Victor A. Hughes has returned to Jacksonville from St. Louis where he was associated with Washington University School of Medicine. He has just completed three years' postgraduate work in gynecology, radiology and obstetrics in Barnes Hospital, St. Louis Maternity Hospital and Barnard Cancer Hospital in St. Louis.

Dr. Hughes had his initial two years' hospital training at Duval County Hospital (now Duval Medical Center) and practiced in Jacksonville ten years prior to entering military service. He has opened offices in the McEuen Building, Jacksonville, and will limit his practice to gynecology and gynecologic radiology.

Dr. Eugene S. Gilmer of Tampa visited clinics in New York, Maryland and New Hampshire during the month of September.

Dr. Richard S. Gill of West Palm Beach attended a reunion of the medical alumni of the University of Virginia in September. He also visited a number of clinics in Virginia.

Dr. John W. Snyder of Miami has returned to his practice after an extensive trip through the North and West. After attending a Mayo Clinic reunion in Rochester, Minn., Dr. Snyder visited clinics in Seattle and San Francisco before attending a medical meeting in Los Angeles.

Dr. John P. Gifford of Vero Beach was the principal speaker at a meeting of the local Kiwanis Club in September. His subject was "Recent Advances in Modern Medicine."

Dr. Russell B. Carson has returned to Ft. Lauderdale after spending three weeks in northern cities where he visited experimental laboratories and clinics. His trip took him to Cincinnati, Chicago, Battle Creek and Ann Arbor, Mich., Harrisonburg, Va., and Montreal, Quebec.

Dr. Wiley T. Simpson of Winter Haven recently visited Cook County Hospital in Chicago and Mayo Clinic in Rochester, Minn., en route to Canada, where he visited in Winnipeg.

Dr. John A. Hughes of Coral Gables has recently opened offices at 3723 S. W. Eighth Street. He formerly practiced in Washington, D. C.

Dr. Simon I. Kemp of Miami has opened offices at 2300 Biscayne Boulevard for the practice of obstetrics and gynecology. Dr. Kemp was formerly a member of the Duval County Medical Society in Jacksonville.

Dr. Thomas H. Bates of Lake City visited clinics in Memphis, Tenn., and Little Rock, Ark., and attended homecoming at Tulane University at New Orleans in October.

Dr. Arthur C. Tedford of Melbourne attended the postgraduate course in cardiology at the Michael Reese Hospital in Chicago in August.

Dr. Isaac M. Hay of Melbourne attended a course in surgery at the New York Postgraduate Medical School in August.

Dr. William S. Nichols of Lake City spent a month of September and October visiting clinics in Alabama and Arkansas and also made a trip to Hollywood, Calif.

Dr. Amsie H. Lisenby of Panama City studied surgery at the Temple University Hospital in Philadelphia for two weeks in October.

Dr. Francis P. Meyer, Jr., formerly of St. Petersburg, is the newly appointed assistant dean of Duke University School of Medicine at Durham, N. C. He assumed his duties on November 1.

Dr. George M. Zeagler of Palatka was the guest speaker at the October meeting of the East Palatka Parent-Teacher Association.

Dr. Leroy M. Sutter of Orlando recently spent a month doing gastroscopic examinations and related work with Dr. Rudolph Schindler of Los Angeles, Calif.

Friends of Dr. W. M. Ives of Lake City will be pleased to learn that he has been able to resume a limited portion of his practice after spending several months in a Veterans Administration Hospital. He is president of the Columbia County Medical Society.

Dr. Robert B. Harkness of Lake City attended the Southeastern Regional Conference which was held on October 12 and 13 in Columbia, S. C.

NEW MEMBERS

The following doctors have joined the State Association through their respective county medical societies during the year.

Abbey, Edward A., Ft. Lauderdale
Abbiss, Frederick J., St. Petersburg
Agnew, Harold S., Arcadia
Ajac, John C., Miami Beach
Allgood, Jackson L., Jr., Jacksonville
Anderson, Donald H., Port St. Joe
Anderson, William H., Jr., Ocala
Anstine, Dale T., Hollywood
Antell, Gunnard J., Coral Gables
Askue, Chester M., Ft. Myers
Aucremann, Charles E., Jacksonville
Azmitia, Efrain C., Tampa
Barger, John A., Jr., Tampa
Baxt, Herman, Belle Glade

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Banks, Roland W., Wauchula
Belle, Martin S., Miami
Bennett, Van B., Jasper
Bernstein, Milton, Miami Beach
Binneveld, Geoffrey H., Leesburg
Blackburn, Lester H., Tallahassee
Blackmon, William P., Apalachicola
Boerger, Victor L., St. Petersburg
Boettner, Julius F., Ft. Lauderdale
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Costa, Frank J., Tampa
Coxe, Lemuel F., Jr., Panama City
Cravey, George M., Jacksonville
Cunningham, James J., New Smyrna Beach
Currie, Howard F., DeFuniak Springs
Dann, Thomasson P., St. Petersburg
Davidson, James W., Crescent City
Davis, Edwin B., Jr., Palm Beach
Deatsch, Joseph H., Miami
DeWoody, Gerald M., West Palm Beach
Dickens, Benjamin F., Fernandina
Donegan, Charles K., St. Petersburg
Driskell, Melville M., Pensacola
Dunlap, Ernest B., Jr., Jacksonville
Duval, Charles W., Pensacola
Farrington, Joseph, Jacksonville
Farrington, Robert F., Miami
Farrior, J. Brown, Tampa
Farrior, John L., Pensacola
Feintuch, Henry, Miami Beach
Ferguson, Robert W., Umatilla
Fischer, James E., Miami
Flannery, Marvin G., Miami
Fox, Frederick J., Clermont
Garten, Leonard, Jacksonville
Genest, Aloria H., Miami Shores
Gertman, Samuel, Miami
Gibson, Joseph A., Palmetto
Glassman, Herman, Miami
Glenn, Robert B., Jacksonville
Glueckauf, Lewis G., Miami Beach
Goldman, Milton S., Miami Beach
Goldman, Solomon B., Miami Beach
Gonzalez, Edward, Key West
Greene, Ralph N., Jr., Jacksonville
Griffith, Newell J., Winter Haven
Grossman, Leo, Miami Beach
Hall, James B., Jacksonville
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Halpern, Jesse O., Miami Beach
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Jones, James F., St. Petersburg
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Keefe, Jack, 3rd, Miami
Kelley, William H., Orlando
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Kovnat, Maurice, Miami Beach
Kuhn, Mark A. R., Miami
Larsen, Carl J., Avon Park
Leek, Edwin S., Graceville
Lester, Joseph L. G., Jr., Key West
Levy, Morton, Orlando
Lippincott, Leon S., Daytona Beach
Love, Albert G., IV, Gainesville
Love, Cecil E., Gainesville
McCarley, Lynn D., Jr., Miami
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Miller, Royston, Orlando
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Mitchell, Wallace H., Key West
Monaco, Achille A., Bushnell
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Nixon, Samuel P., Ft. Lauderdale
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Patton, Bernard W., St. Petersburg
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Usdin, Daniel R., Jacksonville
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Van Nortwick, William A., Jacksonville
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Watterson, Kenneth W., St. Petersburg
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Editor's Note:

The purpose of the Academy is to promote a program of public relations under the supervision of the Florida Medical Association. At present all officers and members of the Academy are also members of the Florida Medical Association.

Doctors attending the medical district meetings in mid-October had opportunity to hear presented in compact form the purposes and activities of the Florida Academy of Public Medicine. They heard the president-elect of the Florida Medical Assocation, Dr. Walter C. Payne of Pensacola, describe the Academy as a separate corporation which functions as a bureau of the State Association.

Dr. Payne explained that the Academy has two main objectives, each of which is intimately related to the other. First, but not necessarily always foremost, is the general public relations program which endeavors to improve relationships between the profession and the public. Secondly comes the legislative program of the State Association. In this the chief function of the Academy is to serve as a watchdog for the medical profession and to provide informational service for the legislators.

In order that either of these two purposes may be accomplished it is essential that there be close coordination and cooperation between the county medical societies and the state medical Association, the next president told his fellow physicians. In fact, basic operation at the county level is the key to success in both public relations and legislative matters.

The regional groups were reminded of the value of newspapers, radio and medical speakers for lay meetings in getting the profession's story to the public. As an example of one means of doing this with measurable success Dr. Payne displayed copies of a Sunday edition of the Pensacola Journal which contained an eighteen page medical section, sponsored by the Escambia County Medical Society.

Scarcely a day goes by but that some newspaper in the state carries an editorial on some phase of health and medicine. Most of these editorials are reasonable and understanding in their approach to the problem. There is usually an attempt to present fairly all sides of the issue. Some gently prod the medical profession, and a few become definitely vitriolic.

These should not go unnoticed by the medical profession. Appreciation should be expressed when merited, and constructive criticism from laymen should be welcomed. An attempt should be made to correct conclusions based on inaccurate or inadequate information. The Academy of Public Medicine has assumed this obligation and attempts to provide newspaper editors with additional data on medical and public health topics.

In the November issue of the Journal of the Florida Medical Association such an editorial is reproduced together with the reply from an officer of the Academy. There is no intention on the part of the Academy to enter into drawn-out fruitless arguments, nor to create an impression of resenting sincere constructive criticism. The sole objective is to present to the editors a side of the picture too frequently left untold.

Newspaper editors are interested in doctors and what they are doing. That interest is certain evidence that there is a demand by the public for information of this nature. The doctor is still one of the most important personages in any community.

The press coverage given to two different medical activities during the latter part of October is proof that all this is not wishful conjecture. During the recent medical district meetings newspapers in the host cities either assigned reporters to the meetings or made certain that they would be given the essential information. At Sarasota there appeared a reporter from the

Tampa Tribune. His story the following day proved that he had not been present out of idle curiosity.

From the Southern Medical Association session in Miami in late October there daily appeared press bureau stories that went out for nationwide distribution.

COMPONENT SOCIETY NOTES

ALACHUA

The 1948 state dues for the Alachua County Medical Society have been paid by the entire membership.

BAY

At the October meeting, members of the Bay County Medical Society formulated plans for the incorporation of the society. A scientific paper was read by Dr. Chas. T. Barton who chose as his subject, "Effect of Sinus Infections of the Eye."

Members who attended the meeting were: Drs. Chas. T. Barton, Lemuel F. Coxe, Jr., Charles H. Daffin, Donald S. Fraser, James E. Kerr, M. J. Lingo, James M. Nixon, Martle F. Parker, Franklin H. Reeder, William C. Roberts and Russell T. Stewart. Among the guests was Dr. W. H. Jackson of the Venereal Disease Control of the Florida State Board of Health.

BREVARD

The regular meeting of the Brevard County Medical Society was held on October 12 in Cocoa. Sixteen members and guests attended the dinner which was followed by a short business meeting.

LEON-GADSDEN-LIBERTY-WAKULLA-JEFFERSON

All members of the Leon-Gadsden-Liberty-Wakulla-Jefferson County Medical Society have paid their 1948 dues to the State Association.

MARION

At the October meeting of the Marion County Medical Society, Dr. Rollin D. Thompson, director of the Florida State Tuberculosis Sanitarium at Orlando and president-elect of the National Tuberculosis Association, spoke on "The Sanitarium."

Dr. Eugene G. Peek, Sr., made a report on the Northeast Medical District Meeting which was held in Daytona Beach.

Dr. Richard C. Cumming, vice president, presided in the absence of Dr. Hugh H. Barfield, president. Members present included Drs. Richard C. Cumming, T. Hartley Davis, Bertrand F. Drake, William H. Garvin, Jr., Henry L. Harrell, Carl S. Lytle, William J. McGovern, John N. Moore, Eugene G. Peek, Sr., Ralph E. Russell, Robert E. Thompson, Thos. H. Wallis and Harry F. Watt. Guests included Mrs. William Stack of the Central Florida Tuberculosis and Health Association and Dr. C. H. Blandford, director of the Marion County health unit.

MONROE

Members of the Monroe County Medical Society met in October with members of the staff of the United States Naval Hospital, Key West. Dr. Allen S. Shepard of Key West was the main speaker.

PALM BEACH

All members of the Palm Beach County Medical Society have paid their 1948 dues to the State Association.

PINELLAS

At the October meeting of the Pinellas County Medical Society, Dr. Francis H. Langley succeeded Dr. M. Eldridge Black as president. Newly-elected officers for the forthcoming year include Drs. Albert R. Frederick, president-elect; Whitman H. McConnell, first vice president;

Franklin W. Roush, Jr., second vice president; Whitman C. McConnell, secretary-treasurer; Robert C. Lonergan and Walter H. Winchester, censors.

The retiring chairmen of the various society committees made their final reports.

New members accepted into the society during the past few months include Drs. Roderick C. Webb, Edward L. Cole, Jr., Walter H. Winchester, Bernard W. Patton, Thomasson P. Dann and James F. Jones.

PUTNAM

The October meeting of the Putnam County Medical Society was held on October 12 at the Marion Hotel in Palatka with Dr. Edward W. Ford presiding. Members present included Drs. James W. Brantley, Grover C. Collins, Edward W. Ford, Lawrence G. Hebel, Bernard E. Kane, Claude M. Knight and Joseph E. Rose. Dr. Maurice H. Hall, director of the Putnam County health unit, was a guest.

Dr. James W. Davidson, society secretary, has returned to his practice after several months' illness.

FRANCIS BARTOW ENNEIS

Dr. Francis B. Enneis of Jacksonville died at his home on Sept. 30, 1948, following a heart attack. His health had been failing for several months. He was 54 years of age.

Dr. Enneis was born in Savannah, Ga., in 1894. He received his academic training at the Georgia Military College, the University of Georgia and Washington and Lee University, and his medical degree from Loyola School of Medicine in Chicago in 1918. He was licensed in 1921 and opened his practice in Jacksonville the following year.

He was a member of the American Medical Association, the Florida Medical Association and the Duval County Medical Society. Locally, he was a member of the Masonic Order, the Shrine and the Morocco Temple. He attended the Riverside Presbyterian Church.

Dr. Enneis is survived by his widow, Mrs. Marjorie Sawyer Enneis; a daughter, Miss Maxie N. Enneis; a son, Francis B. Enneis, Jr.; and a sister, Mrs. Due Millsaps, all of Jacksonville.

JAMES HARDY PITTMAN

Dr. James H. Pittman of West Palm Beach died at his home on Sept. 23, 1948. In failing health for some time, he had been seriously ill only since mid-July. He was 75 years of age.

Dr. Pittman was born on Sept. 1, 1873 at Bells, Tenn., the son of Orin L. and Annie Hardy Pittman. Following his graduation as a pharmacist at Vanderbilt University in Nashville, Dr. Pittman became Palm Beach's pioneer pharmacist in 1894, establishing his pharmacy in the Royal Poinciana Hotel. After a short time, he returned to Vanderbilt University to enter the School of Medicine and teach in the School of Pharmacy. He was graduated as a Doctor of Medicine in 1899 and was licensed the following year.

He served his internship in Jacksonville and then entered the private practice of medicine in that city. In addition to his private work, he was chief surgeon for the Jacksonville Terminal Company, serving many railroads for a number of years. Because of ill health Dr. Pittman planned to retire when he moved to West Palm Beach in 1924. He soon resumed his practice there, however, and also served as United States Public Health officer.

Dr. Pittman engaged in extensive postgraduate study in New York and in Baltimore. He was a staff member of Good Samaritan and St. Mary's hospitals in West Palm Beach.

He was a fellow of the American Medical Association, a life member of the Florida Medical Association, which he had served as a councilor, and a member of the Palm Beach County Medical Society. He also was a thirty-second degree Mason and a life member of the Shrine.

Survivors include his widow, Mrs. Josephine Hitchcock Pittman; a daughter, Mrs. Dorothy Cooper of McMinnville, Tenn.; two brothers, A. P. Pittman of Nashville, Tenn., and Edwin Pittman of El Paso, Tex. He was a cousin of Dr. Frederick Hardy Bowen of Jacksonville.

WOMAN'S AUXILIARY
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Mrs. F. M. Parish, Bulletin.....*Orlando*

TO ALL PHYSICIANS' WIVES IN FLORIDA:

We are on the threshold of another year's work, which means opportunity as well as responsibility for real results as a medical auxiliary organization. Physicians' wives are the leaders in every community. Today they have a wonderful opportunity to see that health and medical subjects are presented by the proper persons in their community. Let us see that we fulfil our obligation, for it is an obligation.

Now is the most opportune time to increase our membership and influence. It has been said that women throughout the United States are overorganized and have no time for anything more. I have used the same arguments myself. But, coming down to brass tacks, the maintenance of our husbands' profession is being openly challenged by various groups. Looking at it from this standpoint, what other study, civic or social group should rate priority?

From a report at the Twenty-Fifth Annual Meeting of the Woman's Auxiliary to the American Medical Association, held in Chicago June 21-25, 1948, the total national membership was 42,262, an increase of more than 7,000 during the past year. Each doctor's wife in Florida might ask herself this question, "Did I make my contribution to this increase by being a member of the auxiliary in my state?"

Dr. Edward L. Bortz, immediate past president of the American Medical Association, made the following statement in an address at the annual meeting held in Chicago: "In the field of human relationships, the Woman's Auxiliary is our most valuable asset. The response with which the splendid women have carried the message of American medicine into the various forums, clubs, associations and councils of lay groups is an important service to the country." The American Medical Association fully appreciates our power to assist, and we would be remiss indeed were we not to live up to those expectations.

Surely, all doctors' wives will be only too glad to become active auxiliary members when they are informed of the good that we are doing and can do for the future. Let us strive to have every unorganized county in our state organized. If there is not an auxiliary in your county, you are urged to write to the Chairman of Organization for assistance. We are counting on you!

Sincerely yours,
Mrs. Robert J. Jahn
State Organization Chairman

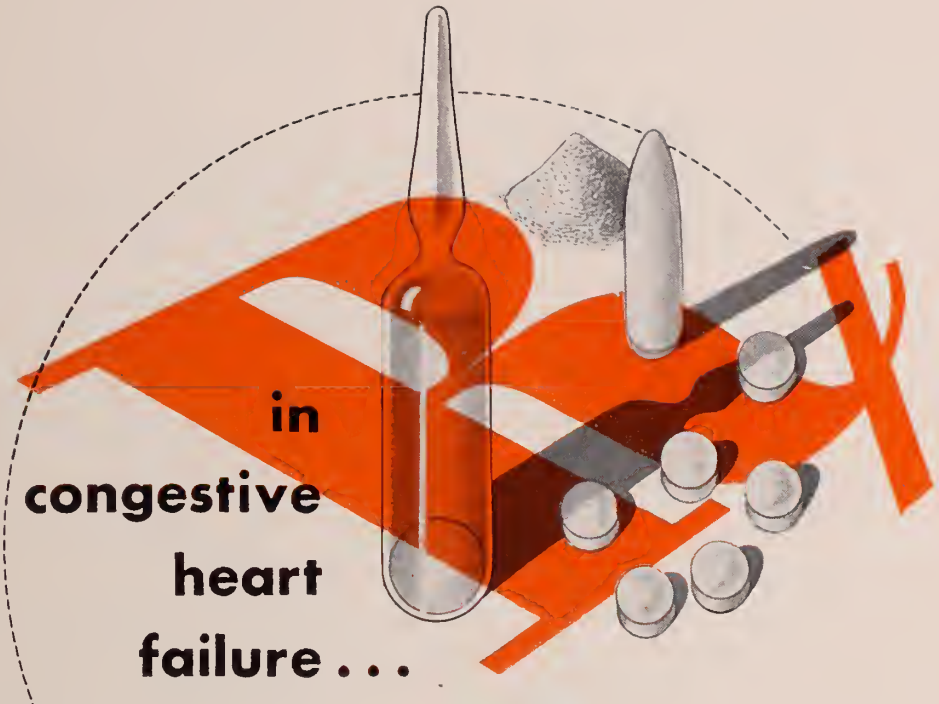


PINELLAS COUNTY AUXILIARY MEETS

The Woman's Auxiliary to the Pinellas County Medical Society had its first fall meeting on Tuesday, October 13, at a luncheon at the Bahama Shores Yacht Club in St. Petersburg. Mrs. Lee E. Parmley of Winter Haven, president of the Woman's Auxiliary to the Florida Medical Association, and Mrs. Wylie L. Tillis of Lakeland, treasurer, were guests of honor.

Miss Lydia Clarkson of Mound Park Hospital, St. Petersburg, addressed the group on the needs of Mound Park student nurses. The auxiliary then voted to provide recreational facilities for the student nurses and to make this the group's project for the year.

Officers for this year are: Mrs. Paul L. White, president; Mrs. Orville N. Nelson, president-elect; Mrs. Richard Reeser, Jr., vice president; Mrs. Harry R. Cushman, recording secretary-historian; Mrs. Whitman McConnell, corresponding secretary; Mrs. Howard H. Curd, treasurer; Mrs. Edward V. Pollard, projects chairman; Mrs. G. Frederick Hieber, program and hospitality chairman; Mrs. Rowland E. Wood, publicity chairman; Dr. Whitman H. McConnell, medical advisor.



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1. Orgain, E. S.: The Treatment of Congestive Heart Failure, North Carolina M. J. 8:125 (March) 1947.

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From where I sit
by Joe Marsh

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And I just couldn't help thinking that there was a real lesson for married folks in the way that Dutch and his missus have got along together—in their policy of live-and-let-live, with never a criticism of each other's differences in taste.

From where I sit, it's due to two things: Temperance—as that moderate preference for beer suggests, and Tolerance—for their own differences of opinion—and for the tastes of others, whether applied to beer, to politics, or how to celebrate an anniversary.

Joe Marsh

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Surgical Pathology every Two Weeks.
GYNECOLOGY—Intensive Course, Two Weeks, starting February 21, March 21.
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	Escambia *Santa Rosa*	Joe I. Turberville, M.D. Century	Nathan S. Rubin, M.D. 5 E. Gregory St. Pensacola	2nd Tuesday 8:00 P.M.	60	59	
	Franklin-Gulf	T. Meriwether, M.D. Wewahitchka	J. R. Norton, M.D. Port St. Joe	3rd Tuesday Odd Months	8	6	A-1-50 William P. Hixon, M.D. Pensacola
	Jackson *Calhoun*	Courtland D. Whitaker, M.D. Burton Bldg. Marianna	Francis M. Watson, M.D. 120 Deering St. Marianna	3rd Thursday 7:30 P.M.	15	100%	
	Walton-Okaloosa	Ralph B. Spires, M.D. DeFuniak Springs	Arthur G. Williams, Sr. Lakewood	3rd Thursday 8:00 P.M.	13	100%	
	Washington-Holmes	N. J. Dawkins, M.D. Vernon	B. W. Dalton, M.D. Chipley		5	100%	
	Columbia *Baker-Hamilton*	W. M. Ives, M.D. 20 W. Madison St. Lake City	Thomas H. Bates, M.D. 27 W. Madison St. Lake City	1st Monday 7:30 P.M.	14	100%	
	Leon-Gadsden-Liberty-Wakulla-Jefferson	Taylor W. Griffin, M.D. Quincy	Edward C. Love, Jr., M.D. Masonic Temple Bldg. Quincy	Quarterly 7:30 P.M.	47	100%	A-2-49 Irby H. Black, M.D. Live Oak
	Madison-Suwannee	C. LeRoy Adams, Jr., M.D. Parshley Bldg. Live Oak	Irby H. Black, M.D. 918 W. Howard St. Live Oak		9	100%	
	Taylor *Dixie-Lafayette*	Walter J. Baker, M.D. Foley	Ralph J. Greene, M.D. Perry	Last Friday 8:00 P.M.	4	100%	190
B	Alachua *Bradford, Gilchrist Union*	J. Maxey Dell, Jr., M.D. 331 W. Main St., S. Gainesville	F. Emory Bell, M.D. Box 400 Gainesville	2nd Tuesday 8:00 P.M.	34	100%	
	Duval *Clay*	John A. Beals, M.D. 1900 Boulevard Jacksonville	Elmer E. Leitner, M.D. 33 W. Ashley St. Jacksonville	1st Tuesday 8:15 P.M.	244	237	
	Marion *Levy*	Hugh H. Barfield, M.D. 1317 S. Orange St. Ocala	Bertrand F. Drake, M.D. Professional Bldg. Ocala	3rd Wednesday 12.30 P.M.	30	27	B-3-50 Charles C. Grace, M.D. St. Augustine
	Nassau	David G. Humphreys, M.D. Fernandina	John W. McClane, M.D. Fernandina	Last Friday 8:00 P.M.	9	100%	
	Putnam	Edward W. Ford, M.D. Crescent City	James W. Davidson, M.D. 6 S. Main St. Crescent City	2nd Tuesday 6:00 P.M.	9	100%	
	St. Johns	Hardgrove S. Norris, M.D. 168 Marine St. St. Augustine	S. Raymond Cafaro, M.D. Exchange Bank Bldg. St. Augustine	3rd Tuesday 8:30 P.M.	15	100%	
	Brevard	I. Kimhell Hicks, M. D. Melbourne	Theodore J. Kaminski, M.D. Box 576 Melbourne	2nd Tuesday	15	14	
	Lake *Sumter*	Howard G. Holland, M.D. 1112 W. Main St., Leesburg	Matthew Arnow, M.D. Eustis	1st Wednesday 7:30 P.M.	26	25	B-4-49 Rabun H. Williams, M.D. Eustis
	Orange *Osceola*	Rollin D. Thompson, M.D. Box 3513 Orlando	James G. Economon, M.D. 108 E. Central Orlando	3rd Wednesday 8:00 P.M.	134	132	
	Seminole	Harry Z. Silsby, M.D. Box 642 Sanford	Frank L. Quillman, M.D. Box 158 Sanford	2nd Tuesday 5:30 P.M.	10	100%	
	Volusia *Flagler*	Charles E. Tribble, M.D. DeLand	Robert L. Miller, M.D. 258½ S. Beach St. Daytona Beach	2nd Tuesday 7:30 P.M.	51	100%	577
C	Hillsborough	Douglas D. Martin, M.D. 442 W. Lafayette St. Tampa	Herschel G. Cole, M.D. 315 Wallace S. Bldg. Tampa	1st Tuesday 8:00 P.M.	149	147	
	Manatee	Millard P. Quillian, M.D. Walcaid Bldg. Bradenton	Willett E. Wentzel, M.D. Professional Bldg. Bradenton	3rd Tuesday 7:00 P.M.	18	100%	C-5-49 John M. Butcher, M.D. Sarasota
	Pasco-Hernando-Citrus	William G. Mason, M.D. Inverness	W. Wardlaw Jones, M.D. Box 247 Dade City	2nd Thursday 7:00 P.M.	14	100%	
	Pinellas	Francis H. Langley 190 18th Ave. St. Petersburg	Whitman C. McConnell, M.D. 313 First Federal Bldg. St. Petersburg	1st Monday 6:30 P.M.	157	100%	
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	DeSoto-Hardee-Highlands-Charlotte-Glades	Zaven M. Seron, M.D. Sebring	Howard V. Weems, M.D. 22 Oak St. Sebring	2nd Tuesday 8:00 P.M.	26	25	C-6-50 H. Quillian Jones, M.D. Ft. Myers
	Lee *Collier, Hendry*	Harvie J. Stipe, M.D. 210 Richards Bldg. Ft. Myers	H. Quillian Jones, M.D. 311 Professional Bldg. Ft. Myers	3rd Tuesday 7:30 P.M.	22	100%	
	Polk	Chester H. Murphy, M.D. Bartow	John W. Vaughn, M.D. Box 475 Lakeland	2nd Wednesday 7:00 P.M.	76	73	485
D	Indian River	James C. Robertson, M.D. Vero Beach	William L. Fitts, 3rd, M.D. Vero Beach Arcade Vero Beach	2nd Tuesday 8:00 P.M.	8	100%	
	Palm Beach	Victor Clarholm, M.D. Box 672 West Palm Beach	Ralph M. Overstreet, Jr., M.D. 820 Comeau Bldg. West Palm Beach	3rd Monday 8:00 P.M.	90	100%	D-7-50 Erasmus B. Hardee, M.D. Vero Beach
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	Broward	Milton N. Camp, M.D. 720 Sweet Bldg. Ft. Lauderdale	Alva R. Taylor, M.D. 414 Blount Bldg. Ft. Lauderdale	4th Tuesday 8:00 P.M.	63	100%	D-8-49 Russell B. Carson, M.D. Ft. Lauderdale
	Dade	Robert T. Spicer, M.D. 1110 Huntington Bldg. Miami	Benjamin G. Oren, M.D. 628 duPont Bldg. Miami	1st Tuesday 8:30 P.M.	488	470	
	Monroe	James B. Parramore, M.D. 523 Whitehead St. Key West	Herman K. Moore, M.D. 600 Elizabeth St. Key West	2nd Thursday 8:00 P.M.	13	100%	675

*Supervise and aid until organized separately.

Total 1927

SCHEDULE OF MEETINGS

ORGANIZATION	PRESIDENT	SECRETARY	ANNUAL MEETING
Florida Medical Association	Joseph S. Stewart, Miami	Robert B. McIver, Jacksonville	Belleair, Apr. 10-13, 1949
Florida Medical Districts	Herman Watson, Lakeland	Council Chairman	
A-Northwest	Irby H. Black, Live Oak	William P. Hixon, Pensacola	Quincy, 1949
B-Northeast	Rabun H. Williams. Eustis	Charles C. Grace, St. Augustine	Palatka, 1949
C-Southwest	John M. Butcher, Sarasota	H. Quillian Jones, Ft. Myers	Sebring, 1949
D-Southeast	Russell B. Carson, Ft. Lauderdale	Erasmus B. Hardee, Vero Beach	Ft. Lauderdale, 1949
Florida Specialty Societies			
Derm. and Syph., Soc. of	A. Buist Litterer, Miami	Wesley W. Wilson, Tampa	Belleair, April 10, 1949
Genl. Practice of Med.	M. Crego Smith, Clearwater	Walter E. Murphree, Gainesville	Belleair, April 10, 1949
Health Officers' Society	Roger F. Sondag, Jacksonville	Lorenzo L. Parks, Jacksonville	Belleair, April 10, 1949
Industrial & Railway Surgeons	F. Hardy Bowen, Jacksonville	J. H. Mitchell, Jacksonville	Belleair, April 10, 1949
Neurology & Psychiatry	James G. Lyerly, Jacksonville	William H. McCullagh, Jacksonvill	Belleair, April 10, 1949
Ob. and Gynec. Society	Chas. J. Collins, Orlando	Dorothy D. Brame, Orlando	Belleair, April 10, 1949
Ophthal. & Otol., Soc. of	Bascom H. Palmer, Miami	W. Jerome Knauer, Jacksonville	Belleair, April 10, 1949
Orthopedic Society	Charles B. Mabry, Jacksonville	Eugene L. Jewett, Orlando	Belleair, April 10, 1949
Pathological Society	James N. Patterson, Tampa	Gretchen V. Squires, Pensacola	Belleair, April 10, 1949
Pediatric Association, State	Edgar W. Stephens, W. P. Beach	Hugh A. Carithers, Jacksonville	Belleair, April 10, 1949
Proctologic Society	Dean W. Hart, St. Petersburg	Frederick E. Farrer, Miami	Belleair, April 10, 1949
Radiological Society	James F. Pitman, Lake City	Floyd K. Hurt, Jacksonville	Belleair, April 9-10, 1949
Urological Society	Milton M. Coplan, Miami	Russell B. Carson, Ft. Lauderdale	Belleair, April 10, 1949
Florida—			
Academy, Public Medicine	Robert T. Spicer, Miami	Shaler Richardson, Jacksonville	Belleair, April 13, 1949
Basic Science Exam. Board	Paul A. Vestal, Winter Park	M. W. Emmel, D.V.M., Gainesville	
Dental Society, State	Horace L. Cartee, D.D.S., Miami	John I. Todd, D.D.S., Jacksonville	Hollywood, Dec. 12-15, 1948
Hospital Association	Mr. James T. Pate, Jacksonville	Mr. H. A. Schroder, Jacksonville	
Hospital Service Corporation	Mr. W. E. Arnold, Jacksonville	Mr. H. A. Schroder, Jacksonville	
Medical Examining Board	Homer L. Pearson, Jr., Miami	Frank D. Gray, Orlando	
Medical Postgraduate Course	Turner Z. Cason, Jacksonville	Chairman	
Medical Service Corporation	Leigh F. Robinson, Ft. Lauderdale	Herbert E. White, St. Augustine	
Nurses Association, State	Mrs. Elsie M. Airheart, Tampa	Miss Helen Shearston, Miami	Sarasota, October, '49
Pharmaceutical Association, State	Mr. D. M. Weaver, Miami	Mr. R. Q. Richards, Ft. Myers	
Public Health Association	Turner E. Cato, Miami	Mr. Fred B. Ragland, Jacksonville	West Palm Beach, Oct. 6-8, '49
Tuberculosis & Health Assn.	Judge Ernest E. Mason, Pensacola	Mr. Walton MacJordan, Orlando	May, 1949
Woman's Auxiliary	Mrs. L. E. Parmley, Winter Haven	Mrs. C. R. Morgan, Jr., Miami	Belleair, Apr. 10-13, 1949
American Medical Association	R. L. Sensenich, South Bend. Ind.	Geo. F. Lull, Chicago	Atlantic City, June 6-10, 1949
Southern Medical Association	E. L Henderson, Louisville. Ky.	C. P. Loranz, Birmingham	Cincinnati, Nov. 14-17, '49
Alabama Medical Association	J. Paul Jones, Camden, Ala.	Douglas L Carnon, Montgomery	Montgomery, Ala., Apr. 19-21, 1949
Georgia, Medical Assn. of	Edgar Hill Greene, Atlanta	Edgar D. Shanks, Atlanta	Savannah, Ga., May 10-13, '49
E. Hospital Conference	Mr. Burton M. Battle, New Orleans	Mr. R. F. Whitaker, Atlanta	Biloxi, Miss., April 27-29, '49
Southeastern Allergy Assn.	Clarence L. Laws, Atlanta	Kath. B. MacInnis. Columbia, S. C	Durham, N. C., Jan. 22-23, '49
Southeastern, Am. College Phys.	Webster Merritt. Jacksonville	Florida Program Chairman	Atlanta, Dec. 4, 1948
Southeastern, Am. Urological Assn.	Harold P. McDonald, Atlanta	Russell B. Carson, Ft. Lauderdale	Boca Raton, March 21-24, '49
Southeastern Surgical Congress	Gilbert Douglas, Birmingham. Ala.	B. T Beasley, Atlanta	Biloxi, Miss., Jan. 24-27, '49

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*R. H. Follis, D. Jackson, M. M. Eliot, and E. A. Park: Prevalence of rickets in children between two and fourteen years of age, Am. J. Dis. Child. 66:1-11, July 1943.

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The Journal OF THE FLORIDA MEDICAL ASSOCIATION

Vol. XXXV JANUARY, 1949 No. 7

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Superior Laryngeal Neuralgia
Charles C. Grace

Pericardial Celomic Cyst
James L. Gouaux, Henry J. Jensen and H. Gerald Morin

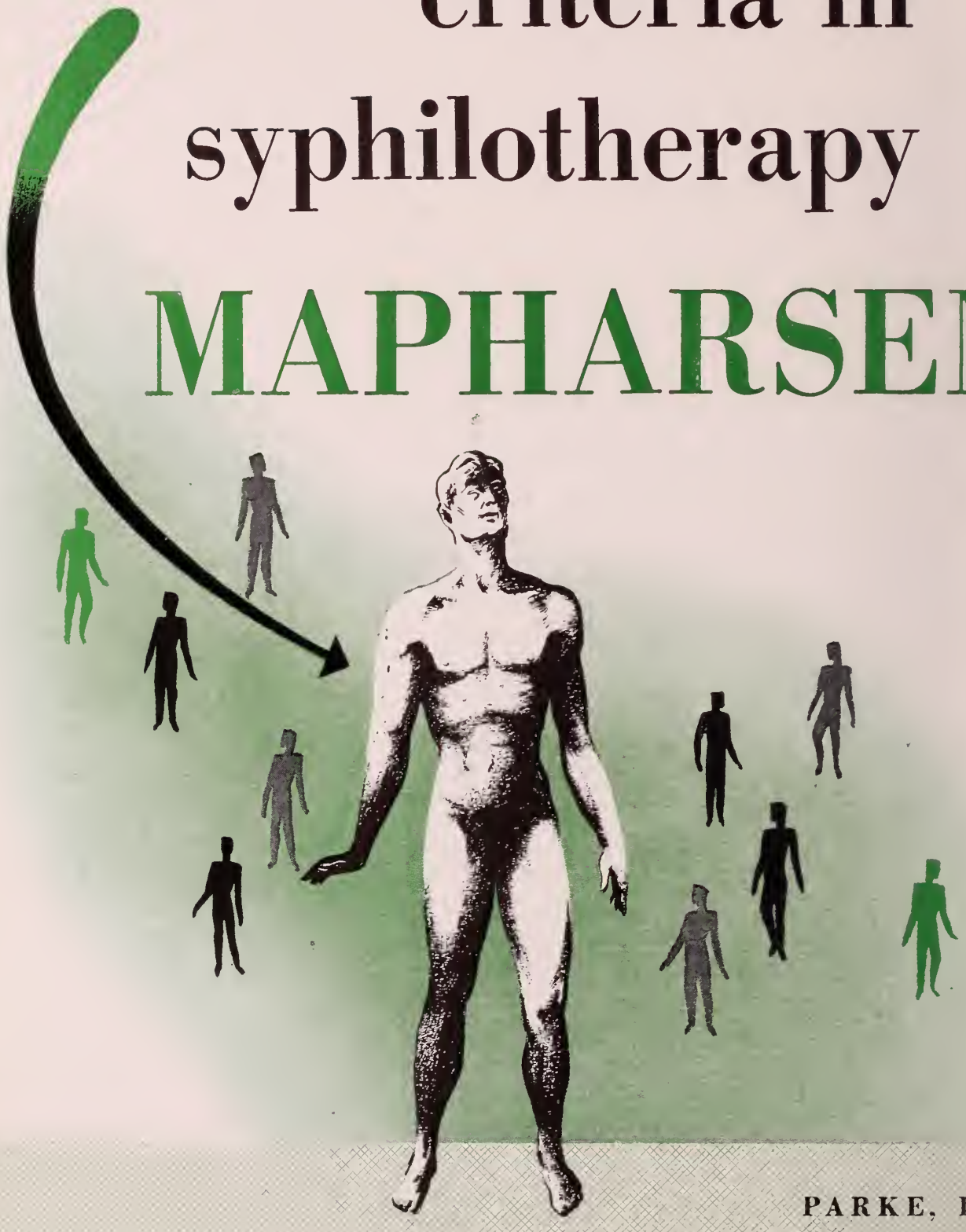
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criteria in syphilotherapy

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*Cecil, R. A.: A Textbook of Medicine. Philadelphia, W. B. Saunders Co., 1947, p. 376.

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Volume XXXV JANUARY, 1949 No. 7

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This Journal is not responsible for the opinions and statements of its contributors.

Published monthly at Jacksonville, Florida. Price $5.00 a year; single numbers, 50 cents. Address Journal of the Florida Medical Association, P. O. Box 1018 (Fla. Theater Bldg.), Jacksonville 1, Fla. Telephone 6-1571. Accepted for mailing at special rate of postage provided for in Section 1103, Act of Congress of October 3, 1917; authorized October 16, 1918. Entered as second-class matter under Act of Congress of March 3, 1879, at the post office at Jacksonville, Florida. October 23, 1924.

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References: 1. Dodd. K. and Minot, A. S.: *J. Pediat.*, 8:442, 1936.
2. Dodd. K. and Minot, A. S.: *J. Pediat.*, 8:452, 1936.
3. Sahyun, M.: *Am. J. Dig. Dis.*, 13:59, 1946.

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*Beams, A. J., and Endicott, E. T., Histologic changes in the livers of patients with cirrhosis treated with methionine, Gastroenterology 9:718-735 (Dec.) 1947.

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[1] Nutrition in Diabetes, Nutrition Rev. *6*:257 (Sept.) 1948.

[2] Diabetes and Arteriosclerosis in Youth, Editorial, J.A.M.A. *135*:1074 (Dec. 20) 1947.

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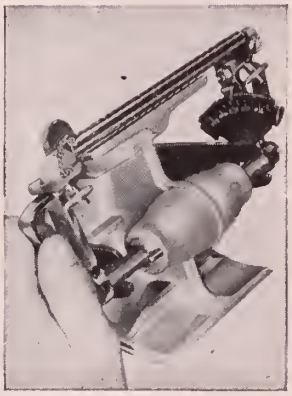
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1. Follis, R. H., Jackson, D., Eliot, M. M., and Park, E. A.: *Am. Jour. Dis. Child.*, 66:1, July, 1943.
2. Stearns, G.: *Jour. Lancet*, 63:344. Nov., 1943.

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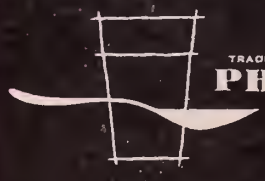


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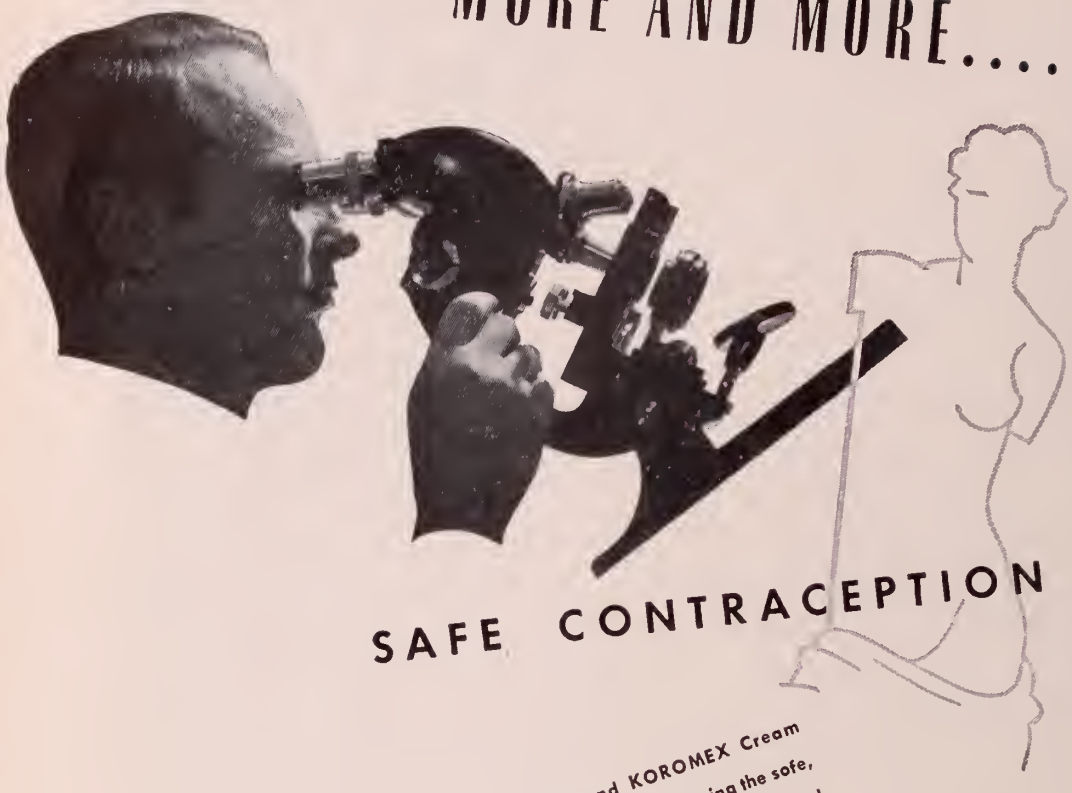
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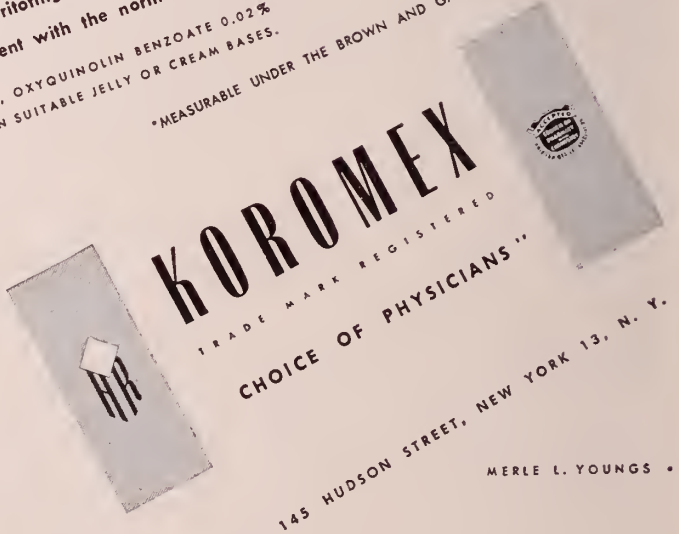


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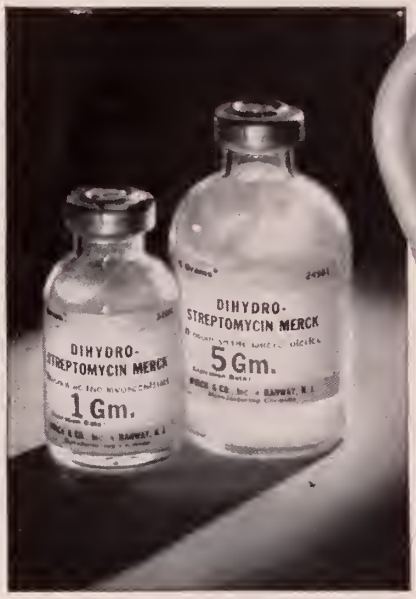
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THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION
PUBLISHED MONTHLY
Volume XXXV Jacksonville, Florida, January, 1949 No. 7

Bronchogenic Carcinoma: Report of Three Cases

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AND
WILBUR C. SUMNER, M.D.
JACKSONVILLE

The purpose of this paper is to review and present some of the established facts concerning bronchogenic carcinoma. In recent years, a number of outstanding surgeons and internists have shown considerable interest in this field. There is, however, a need for even more interest among the members of the profession in general if the successful treatment of this disease is to be accomplished.

HISTORY

Bronchogenic carcinoma is a "young disease." It is only in recent years that many successful cures have been established. The reasons for this delayed success are many, but among those that should be mentioned is incorrect diagnosis resulting in improper treatment. As late as 1912, Adler considered and stated that primary malignant neoplasia of the lung was among the rarest of diseases. Successful pneumonectomy for bronchogenic carcinoma was first performed by Graham and Singer in 1933 and was done by Rhienhoff about the same time. Since then, many cases have been reported with numerous technics described. Within recent years, the "cures" have been increasing, and this progress should be an incentive for more diligent work and study along this line.

INCIDENCE

Primary bronchogenic carcinoma is a common disease and should be so designated. Bronchogenic carcinoma accounts for approximately 5 to 10 per cent of all carcinoma. It is estimated that fifteen thousand persons die annually of this disease in the United States. It is second, and almost equal in incidence, to carcinoma of the stomach. There is some discussion at present as to whether bronchogenic carcinoma is on the increase or whether physicians are more frequently diagnosing it correctly. Statistics published recently from the large clinics show without much doubt that the incidence of this disease is increasing rapidly.

Bronchogenic carcinoma occurs predominantly in men. A relative increase in women has been reported recently; yet it can be stated that there is a definite sex predisposition to men. A composite of available statistics shows that they are affected three times as often as women. This tumor occurs in all age groups, as is the case with any other cancer, but the greatest frequency is during the fifth and sixth decades of life, the average age being 52½ years.

ETIOLOGY

As is true of all cancer, the etiology of bronchogenic carcinoma is still undetermined. There are, however, certain known facts relative to the causative factors. The most important of these is chronic irritation of the bronchial mucosa. There is still much controversy as to what agents and conditions are most likely to be the causative factors. Current discussion seems to center around the following: (1) cigaret smoke, (2) petroleum derivatives, (3) dust, (4) infection, (5) trauma and (6) tar from paved roads. Of these, the first three seem to be the most chronic offenders. What irritants in cigaret smoke play the major role have not been determined. There are several which may act together, namely, (1) nicotine, (2) phenolic bodies, (3) arsenic, (4) ammonia and (5) certain hygroscopic bodies. In an attempt to determine whether cigaret smoke or exhaust fumes was the most predominant irritant, Ochsner, Dixon and DeBakey graphed the incidence of bronchial lesions against the sale of automobile tags and the sale of cigarets. They found no parallelism between this incidence and the sale of automobile tags, but noted a distinct parallelism between the sale of cigarets and the incidence of bronchogenic carcinoma.

PATHOLOGY

Carcinoma involving the lung is limited almost entirely to the bronchial epithelium with occasional primary lesions beginning in the alveoli.

The right lung is involved more frequently than the left and chiefly in the lower lobes. A large majority of malignant bronchial tumors begin in the region of the hilus, which accounts for some of the symptoms to be mentioned later.

The tumors may be classified as squamous cell epitheliomas, adenocarcinomas, or mixed tumors. One can find in the literature many different types of classifications. Recently complicated classifications have been discarded. Boyd classifies these tumors as (1) anaplastic or undifferentiated, (2) medullary, (3) adenocarcinoma and (4) squamous. The great majority are squamous and are generally thought to be the type best suited for surgery.

Metastasis occurs by direct extension through the lymphatics, through the blood stream and by bronchial embolism. The lymph nodes in the mediastinum and around the bronchi are the most frequent sites. The liver is involved more frequently than any other organ. Also often involved are the bones, adrenal glands, kidneys, brain and pleura. In some cases involvement of the superficial lymph nodes and skin is observed.

Metastasis is considered by many to occur early. This impression undoubtedly is due to the fact that diagnosis is made late. Ochsner and his associates were of the opinion that bronchogenic carcinoma grows fairly slowly and metastasizes late. This conclusion was based on numerous autopsies in which carcinoma of the bronchus was found without evidence of metastasis. The grade of malignancy is, however, the greatest factor in determining the rate of spread. The cell type of the tumor is also a factor which must be considered. The more undifferentiated tumors, such as the so-called "oat cell" tumor, metastasize much more rapidly than a grade II or grade III squamous cell tumor. It goes without saying that the size of the tumor is no index as to the age or degree of malignancy.

DIAGNOSIS

Unfortunately, there are no characteristic symptoms of bronchogenic carcinoma. This lack undoubtedly is one of the factors retarding early diagnosis. The symptoms are those of any chronic disease of the lung and in many instances those of the more acute infections. Patients in the cancer age presenting signs and symptoms of pulmonary disease that offer diagnostic difficulty should be considered candidates for bronchogenic carcinoma. Many patients have recurrent episodes of acute pulmonary infections, so-called pneumonia, without further investigation. Often patients have repeated abscesses of the lung, which may have as a causative factor bronchogenic carcinoma. Not infrequently the abscess is due to the carcinoma blocking the bronchus. Any patient past 40 years of age having an abscess of the lung should be studied thoroughly for bronchogenic carcinoma.

Cough is the most frequent symptom. At first nonproductive, it is later accompanied by expectoration. It is important to note that most patients have some form of cough which they attribute to cigarets. Nevertheless, any cough which has changed in character recently is of extreme importance. Hemoptysis is often noted and in many instances may be the first symptom for which the patient seeks medical advice. Pain in the chest, dyspnea and unilateral wheezing are sometimes complained of, but these are usually late symptoms. The wheeze may be due to obstruction of the bronchus and is not necessarily a late sign as the tumor may be protruding early into the lumen of the bronchus. We should like to direct attention to the fact that any patient showing any degree of atelectasis of the lung should be studied thoroughly by bronchoscopic examination, and by bronchography with the use of radio-opaque oil if the bronchoscopic examination gives negative evidence of a tumor of the bronchus. Numerous reports of cases have been collected in which there was some atelectasis of either one or more lobes without the physician taking any further steps to determine the cause. Later complete atelectasis due to obstruction of the main bronchus occurred. Excessive weakness and emaciation indicate advanced disease with usually hopeless prognosis. Hoarseness means that the disease has spread to the mediastinum with involvement of the recurrent laryngeal nerve, a condition not necessarily hopeless. Bronchogenic carcinoma occurring in the periphery of the lung or with metastasis to the pleura causes pleural effusion. In cases in which pleural effusion is present, cytologic examination of the fluid often leads to the diagnosis. In summary, the symptoms are largely related to bronchial encroachment, ulceration, obstruction or pleural involvement.

At the Lahey Clinic, Dr. Ralph Adams gives the following symptoms in the percentage in which they occur: (1) cough 93 per cent, (2) pain 54 per cent, (3) productive sputum 53 per cent, (4) hemoptysis 44 per cent, (5) dyspnea 17 per cent and (6) wheeze 14 per cent.

The Pancoast tumor, or superior sulcus tumor, is entirely different. Due to the location of the tumor in the apical bronchi, the early symptoms produced by this tumor are pain down the arm and around the shoulder girdle extending to the fingers, and weakness of the intercostal muscles on that side. Horner's syndrome, arising from pressure of the tumor on the sympathetic nerves, occurs late.

DIAGNOSTIC METHODS

Patients in the cancer age presenting the symptoms described should immediately have a roentgen examination of the chest. In 95 per cent of the cases in which bronchogenic carcinoma proves to be present, the diagnosis may be suspected from the roentgenogram alone. In all cases in which the disease is suspected, a routine bronchoscopic examination should be made. At an early stage this is the only method by which tissue can be obtained for the establishment of a positive microscopic diagnosis. A positive diagnosis can be made in about 90 per cent of the cases in the inoperable group. Bronchography or the intratracheal instillation of iodized oil followed by roentgenographic examination may reveal partial or complete occlusion of a bronchus. Not infrequently the bronchus is tapering in character. This is an important diagnostic finding and in the absence of a satisfactory bronchoscopic examination may lead one to the correct diagnosis.

Aspiration biopsy of the primary tumor is usually not advisable. Definite seeding of the pleura from aspiration was noted in 1 of our cases. Sputum aspirated at the bronchoscopic examination should be studied cytologically, particularly with Papanicolaou stain, as this method often leads to the correct diagnosis. Routine cytologic examination of the sputum in suspected bronchogenic carcinoma should be carried out. Often the patient will present palpable lymph nodes in the supraclavicular and cervical chain which at times may show metastasis. The main diagnostic aid in diagnosing bronchogenic carcinoma is to suspect it.

Every effort should be made to determine the operability of the patient, as needless operations discredit surgical treatment. By the use of the bronchoscope, a biopsy can be made which will determine the type of tumor, and this information will aid in determining the type of treatment. When undifferentiated and "oat cell" tumors are present, operation is not indicated. The operability of the patient is a factor which must be determined by the individual surgeon.

TREATMENT

The only satisfactory treatment for bronchogenic carcinoma is surgical removal of the affected lobe or entire lung. More recent opinions concerning therapy advocate pneumonectomy instead of lobectomy. As in all cancer, if early diagnosis is made, pneumonectomy can be performed with favorable prognosis. The technic of this operation will not be presented here. Radiation has been advocated by some, but the consensus at the present time is that this measure is only palliative. The high voltage roentgen therapy, 1,000,000 k.v.p., may change this view somewhat.

At the seminar on cancer held recently in Jacksonville, Dr. Herbert Adams of the Lahey Clinic stated that in a period of fifteen years the incidence of five year cures among patients having bronchogenic carcinoma who submitted to pneumonectomy is higher than that among patients operated upon for carcinoma of the stomach. The latter disease has been treated surgically for the last forty years or more.

Three cases are presented here to substantiate the fact that bronchogenic carcinoma can be cured if the patient is seen in the early stages and the condition is recognized. The patient in case 1, now more than ten years postoperatively, reports that she is well and rounding up cows on horseback, which denotes considerable activity. The patients in the other 2 cases, one after seven years and the other after six years, reported recently that they are in good health.

REPORT OF CASES

Case 1.—Mrs. B. H., a 26 year old white woman, was admitted to St. Vincent's Hospital on July 26, 1938 with chief complaint of shortness of breath. She had noticed the dyspnea on exertion and after talking for any length of time for over two years and had been told by a physician that enlargement of the heart was the cause of the difficulty in breathing. The previous October, spontaneous collapse of the left lung with pain under the left shoulder blade and palpitation of the heart had occurred. In April and June of that year "polyps" had been removed from the left bronchus, and cough and hemoptysis had followed these treatments. There was no pain or cough at the time of admission to the hospital, and she stated that she felt well. The past history was otherwise noncontributory.

Physical examination disclosed a well developed, well nourished young woman, healthy in appearance and lying comfortably in bed. There was no evidence of dyspnea, jaundice or cyanosis. The only significant findings related to the chest, where a depression on the left side was especially noticeable in the supraclavicular and infraclavicular areas. On examination of the lungs, there was full expansion on the right side, but the left side expanded only slightly with respiration. Fremitus was present on the right side and was only slightly diminished on the left side. On percussion, resonance was normal

on the right side; dulness was noted on the left side, except over an area immediately to the left of the sternum in the region of the third and fourth costal cartilages. There was a hyperresonant area to the right of the sternum in the same region anteriorly. On auscultation, breath sounds were bronchovesicular and vesicular on the right side, and wheezing and high pitched, on the left side anteriorly and posteriorly. Examination of the heart gave essentially negative results.

A diagnosis of tumor of the left bronchus was made and was confirmed by bronchoscopic examination. The tumor was causing atelectasis of the left lung, which was more pronounced in the upper lobe.

On July 29, pneumonectomy was performed on the left side under intratracheal anesthesia with the use of cyclopropane. During the operation, 500 cc. of blood was given, and the immediate postoperative condition was good. Bronchoscopic examination was not required.

Two days later, on palpation, the heart was pulsating to the right, and 450 cc. of bloody fluid was aspirated. On August 2, 70 cc. of brownish fluid was aspirated. Roentgenograms made four days thereafter showed the right lung to be fully expanded and healthy in appearance. The left side of the chest was practically opaque except for the upper sixth and seventh interspaces. The trachea was not displaced. On August 18 the patient was up in a chair and two days later was discharged from the hospital.

The pathologic report follows: "The lung is collasped, airless. The pleural surfaces are roughened. The bronchus is occluded at its upper portion by a tumor mass which is pedunculated. Cell bronchial passages are filled by a thick ropy mucus of light red color. A white, firm mass is found near the surface at a distance of 6 cm. from the bronchial tumor. This is 1 cm. in diameter. The peribronchial lymph nodes are small, dark red to black. Impression: Bronchogenic carcinoma with metastasis to regional lymph nodes (figs. 1, 2 and 3)."



Fig. 2—This photograph shows the adenocarcinoma originating in the main bronchus (case 1).



Fig. 1—Gross specimen of lung removed from the patient in case 1. The tumor is shown completely obstructing the main stem bronchus.

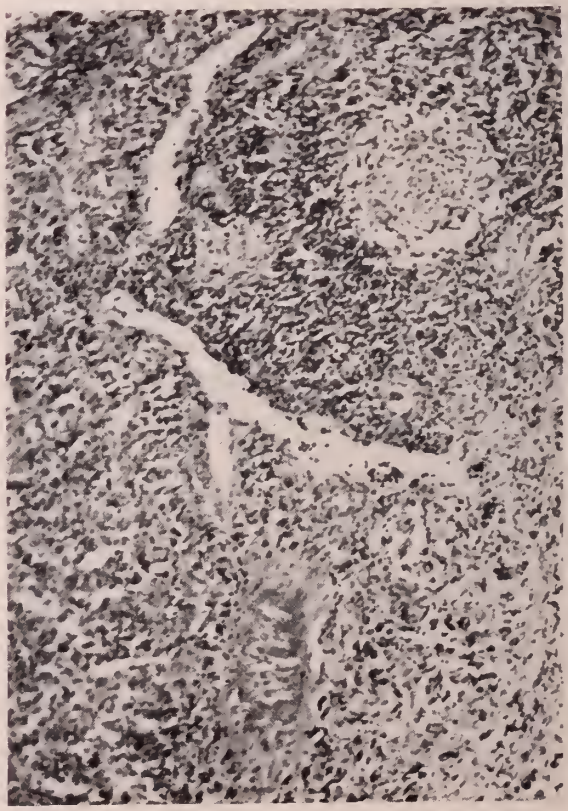


Fig. 3—Metastasis to regional lymph nodes (case 1).

The tissue from the bronchial tumor was examined by three different pathologists, who concurred in the diagnosis of bronchogenic carcinoma with metastasis to the regional lymph nodes. The following microscopic description was given by Dr. Bennett of the Ochsner Clinic:

"This is an adenomatous tumor which appears to have grown through the tissue both inside and outside the bronchial cartilage layer. In addition, there are small islands of tumor tissue beyond the confines of the major mass of tumor cells. Because of these observations I feel that one must regard the tumor as invasive, hence, an adenocarcinoma of bronchogenic origin. A section of lymph node which accompanies the section of lung tumor is more difficult to interpret. A considerable portion of this lymph node has undergone replacement with fibrous tissue and large numbers of cells containing carbon pigment. In addition, this portion of the lymph node contains poorly defined groups of cells that are interpreted as being epithelial in type. These cell groups, together with the fibrous replacement, can be interpreted as metastases from the bronchogenic carcinoma."

Case 2.—Mrs. L. H., a 62 year old white housewife, was admitted to St. Vincent's Hospital on Jan. 5, 1941. She stated that she had been subject to colds and coughs and attacks of bronchitis for at least twenty years. The preceding April, she had had a severe attack of coughing which was worse on arising in the morning. A fair quantity of sputum was present at times, brownish to greyish in color and occasionally blood-streaked. There was no history of chills, night sweats, elevation of temperature or loss of weight, but she had had pneumonia three times, the last time four years previously, and pleurisy four times at least, also typhoid fever at the age of 16 and a tonsillectomy at the age of 40. The menopause had occurred when she was 50 years of age. She had experienced pain in the upper quadrant of the chest on the right side which radiated to the right shoulder. She did not smoke cigarets.

A somewhat obese white woman in her early sixties, the patient appeared neither acutely nor chronically ill although she had frequent spasms of coughing. Physical examination was essentially negative except for some impaired notes on percussion in the bases of both lungs. Breath sounds had some bronchial quality at the base of the left lung. Breath sounds at the base of the right lung were diminished. No rales were heard. Examination of the heart gave essentially negative results.

Bronchoscopic examination revealed approximately 2½ to 3 cm. below the cardia and in the right main bronchus a well formed projecting and rounded tumor mass which at this point half filled the bronchus. More tumor was seen below the projecting and movable portion. It bled easily, and after it was contacted the first time, there was oozing of blood. The upper portion of the tumor extended below the bronchus to the upper lobe of the right lung. The left main bronchus appeared clear.

Prior to operation, artificial pneumothorax was begun to compress the right lung and to accustom the heart to absence of this lung. Pneumonectomy on the right side was then performed under general anesthesia.

On January 16, roentgen study of the chest showed that the right lung was partially compressed by a pneumothorax. The upper lobe was compressed away from the wall of the chest an inch. No evidence of fluid was seen. There were dense changes in the lower lobe of the right lung along the mediastinal margin. The left lung was normal. The glands at the hilus of the right lung were swollen. The heart was not displaced.

Roentgen study on February 10 showed the left lung fully expanded and healthy in appearance. The vertical views showed a fluid level in the right pleural cavity which reached up to the seventh rib. This caused the lower half of the chest on the right side to be opaque. There was evidence of markedly thickened pleura at the apex of the right lung and along the right axillary wall of the chest on the right side down to the fluid level. Pneumothorax was discontinued because of the fluid in the right pleural cavity.

On March 5, roentgen study of the chest with a flat vertical film showed the left lung well expanded and healthy. The right lung had been removed. A drainage tube was well placed in the right pleural cavity, and the tip of the tube was seen lying opposite the spinal end of the fourth rib. No fluid level was seen. The heart was not grossly displaced. A summary of the pathologic studies follows. One of the sections obtained at biopsy with the bronchoscope showed fibrin; the other presented a new growth of columnar epithelium, which formed a rather solid mass. Study with high power magnification, however, showed it to be composed of fairly well formed glands. The surface epithelium was high and columnar. The cells had relatively abundant and fairly clear cytoplasm while the nuclei were small, compact and deeply stained. Diagnosis: adenocarcinoma of moderate grade malignancy.

On gross examination, the lung presented at the first bifurcation of the bronchus a tumor which was soft and projected into the lumen. Its attachment was easily broken. Further section along the course of the bronchus showed a continuation of the tumor. The peribronchial tissues were thickened. All the tissue of the lower lobe here seemed solid and airless. Blood vessels were marked by blood coagula.

Sections of the tumor which partly occluded the bronchus showed on microscopic examination a growth composed of columnar cells in artificial glandular formation. There was very little interstitial tissue and it was loosely arranged. The growth was invasive and in sections of the wall of the bronchus was found to be definitely a part of the bronchial wall. Much of the thickened hard tissue seen on the gross examination was reactive and of inflammatory or fibrous character. Diagnosis: bronchial adenocarcinoma.

The patient was discharged from the hospital on March 30.

Case 3.—Mr. P. B., a 57 year old white man, a train engineer, was admitted to St. Vincent's Hospital on June 15, 1942. He related that he had been expectorating a white, thick, frothy mucus for the last three weeks prior to admission, had lost his appetite and had been losing weight, having lost 20 pounds in the last three months. Other complaints were occasional aching in the chest, frequent vomiting spells, and nausea for the preceding three months. There was a history of the usual childhood diseases, but no pneumonia. He was a heavy smoker.

Physical examination gave essentially negative results except for some loss of weight. Nothing was noted on examination of the lungs to cause one to suspect bronchogenic carcinoma. There was no atelectasis of either lung. There may have been some slightly diminished breath sounds on the right side, but this finding was not definite.

Bronchoscopic examination revealed a rounded mass protruding from the midlateral mass of the right main bronchus. No deformity ulceration was seen. This mass blocked approximately 40 per cent of the lumen as seen. A 7 mm. bronchoscope was passed. An attempt was made at biopsy, but the tissue obtained was not tumor tissue and bleeding resulted.

On June 25, the left lung was fully expanded and healthy in appearance. The right lung was partially compressed by a pneumothorax. The lower lobe of this lung was separated from the wall of the chest for about ¾ of an inch, but otherwise the right lung seemed to extend out to its normal width. A soft tissue mass was seen at the hilus, which measured about 4 cm. in diameter. The appearance of this mass was suggestive of a tumor. There was no evidence of tuberculosis.

Prior to pneumonectomy the right lung was collapsed by artificial pneumothorax. On June 28, pneumonectomy on the right side was done. Convalescence was uneventful and recovery complete.

SUMMARY

Bronchogenic carcinoma should be recognized as a common disease occurring in all age groups, but with greater frequency in men than in women. The symptoms and signs of this disease are those of any chronic condition of the lung, and the physician must always be on the alert for bronchogenic carcinoma if any improvement in treatment is to be made. The fact that only 30 per cent of patients reaching the chest surgeon are amenable to surgery is discouraging.

It should be remembered that for the past fifteen years, during which bronchogenic carcinoma has been attacked surgically, the rate of five year cures is higher than that for carcinoma of the stomach, which has been treated surgically for over forty years. The low percentage of five year survivals in both is probably due to the same reasons, namely, insidious onset and improper early diagnosis. A plea is made for physicians to suspect bronchogenic carcinoma more frequently when patients present themselves with symptoms referable to chronic or acute diseases of the respiratory tract.

Three cases are reported to substantiate the fact that bronchogenic carcinoma is curable. It is especially encouraging that 1 patient is now well and active ten years following pneumonectomy in spite of the fact that there was metastasis to one of the regional lymph nodes at the time of operation. The other 2 patients are well after seven and six years have elapsed.

We wish to express our appreciation to Drs. Louie Limbaugh, Karl B. Hanson, Raymond H. King and W. McL. Shaw, who were members of the chest team which made the diagnosis possible in these cases and who cooperated in bringing about the recovery of these patients.

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238 West Church Street.

Program of the Diabetes Demonstration Unit in Jacksonville and Duval County

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Considerable interest has been expressed in the program of the Diabetes Demonstration Unit established in Jacksonville by the United States Public Health Service in cooperation with state and local public health agencies. As far as is known, this is the first diabetes control project with what might be termed a complete program.

The objective set up in the beginning of this Unit was to work out a program for successful control of complications from diabetes and for the early diagnosis of this condition which might be employed by a local health officer with a minimum of change in his organization and general program. The Unit has been in active operation since May 1947. During that time the personnel has consisted of one physician, one nurse, one nutritionist, two laboratory technicians and one clerk. The program has been roughly divided into three sections, namely, case finding, education of the diabetic and education of the general public.

CASE FINDING

Case finding has been concentrated among the groups of the population which previous studies indicated have a high incidence of diabetes. Of 736 blood relatives of diabetics who were tested, 4.1 per cent had previously undiagnosed diabetes.

United States Public Health Service.

Read before the Florida Health Officers' Society, Third Annual Meeting, St. Augustine, April 11, 1948.

In several of these patients the disease was severe with blood sugar ranging up as high as 450 mg. per hundred cubic centimeters of blood and brick red Benedict's reaction in the urine. In order to contact these persons so that they might be persuaded to present themselves for testing, we first drew up a list of known diabetics in the area from the local hospitals and practicing physicians. The list at the present time exceeds 675 names. The public health nurses of the cooperating agencies then called on these known diabetics and secured certain basic information such as amount of insulin, diet formula, duration of disease and the presence of complications. In addition, a complete list of the blood relations of the diabetic located in the area was obtained together with information as to whether these relatives were known diabetics. A total of 2,019 names of blood relations of diabetics was obtained in this way. Those who were not known to have the disease were then sent a form letter inviting them to attend a series of clinics held in the local health department. A total of 670 of this number presented themselves and were tested following receipt of only one form letter.

The other groups in the population toward which concerted effort for testing is being made are employees of department stores, members of women's clubs, workers in industries employing large numbers of women, food handlers and the Jewish population. Judging by previous papers in the literature all of these groups could be considered to have a high incidence of diabetes. The results of these latter studies have not been analyzed at present.

EDUCATION OF THE DIABETIC

The second phase of the program was also a very gratifying endeavor. It has been said by practically every leading diabetes specialist that the education of the diabetic patient is one of the most potent factors in prolongation of life and avoidance of complications. Proceeding on this premise we organized a series of classes of instruction for diabetics beginning in August 1947. These classes were conducted by a physician, nurse and nutritionist. To date 312 persons have attended these classes, 70 of whom were friends or relatives of a diabetic. We have had many statements of appreciation from both patients and physicians for this phase of our work.

While the physician who is responsible for the case is the most logical person to instruct the patient, very few physicians have the time or the office personnel to devote to this need. Certainly in Jacksonville public health workers have been a great aid to the practicing physician in caring for his diabetic patients and, we believe, in increasing the length of life and efficiency of diabetics. Certainly the public health worker has a background which fits him for this type of work. One of the traditional public health services is health education, and physicians, nurses and other professional public health groups have done excellent educational work in such fields as prenatal and infant care. We believe that there can be a future for public health workers in education of the diabetic patient. A monthly bulletin is also sent to all known diabetics in the area.

EDUCATION OF THE PUBLIC

Our public education program has followed the usual lines of approach such as talks to groups, radio addresses and distribution of printed material. We have endeavored to channel the bulk of this information toward groups in which there is believed to be a high incidence of diabetes. While the exact etiology of diabetes is unknown, it has been shown repeatedly that the factors of overweight and heredity are frequently associated with its onset. Our educational campaign has been based on the premise that these can be points of attack in a prevention program.

Plans for a follow-up system are to be worked out with the cooperating agencies and the local medical profession. Such a program will bring up many problems, but we believe it will produce worth while results. We are also constructing a register of cases which will coordinate our work in all its phases.

Our program is at the present time only in its inception, and we may find that some of the approaches have been wrong. It was thought, however, that the members of this society might be interested in the lines along which we have been working and in the results obtained to date. We sincerely invite all interested public health workers to visit our Unit in Jacksonville and after observing at first hand what we are doing, to give us their ideas on our program.

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Superior Laryngeal Neuralgia

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Superior laryngeal neuralgia is a rare condition, but is a definite clinical entity just as are similar affections of the glossopharyngeal and trigeminal nerves. It was first described by Avellis[1] in 1900. Six years later, Boenninghaus[2] in reporting 82 cases of laryngeal pain stated that in 4 it was neuralgic. Four cases have been described in British and American literature. In Great Britain, Harris[3] in 1926 reported the only case. In the United States 3 cases have been recorded. The first was reported by Echols and Maxwell[4] in 1934, and, in 1941, 2 cases were reported by Smith, Moersch and Love[5] of the Mayo Foundation, who stated that a search of the records of the Clinic did not reveal a previous case in which this diagnosis had been made. Others reporting cases were Levy[6] 1 case in 1923, Halphen[7] 3 cases in 1924, Hutter[8] 3 cases in 1929, and Bertoin[9] 2 cases in 1946, making a total of 18 cases now published.

ANATOMY

The superior laryngeal nerve, a branch of the vagus, arises from the ganglion nodosum and extends downward and inward behind and beneath the external carotid artery toward the superior thyroid cartilage. Just below the hyoid bone the nerve divides into two branches, the external and internal. The external branch is motor and supplies mainly the cricothyroid muscle. The internal branch, with which this report is concerned, pierces the hyothyroid membrane near its midportion and comes forward in the plica of mucous membrane at the upper edge of the pyriform sinus and supplies sensory fibers to both surfaces of the epiglottis, the aryepiglottidean folds, mucous membranes of the larynx and the base of the tongue. The superior laryngeal nerve sends fibers to the pharyngeal plexus, which also anastomoses with the glossopharyngeal nerve and the sympathetic chain.

ETIOLOGY

Hutter[8] voiced his belief that there is some connection between neuralgia of the superior laryngeal nerve and affections of the mucous membrane near its sensory endings. He suggested that it may be due to a spreading of the inflammatory processes of the upper part of the pharynx into the pyriform sinus and direct irritation by way of the plica of the nerve. He also believed that there may be some likelihood that tonsillectomy may be a predisposing factor when unskillfully done. It is well known that some of the virus infections, such as influenza, show a predilection for nervous tissue. Halphen[7] and Bertoin[9] stressed this fact as an important etiologic factor.

SYMPTOMS AND DIFFERENTIAL DIAGNOSIS

This condition presents characteristic features and findings. The pain is very excruciating and knifelike in character, and is usually paroxysmal, resembling neuralgia of the trigeminal nerve. The patient, however, has not the slightest hesitancy in being able to locate quickly and accurately the point of pain by placing the tip of a finger over the superior portion of the thyroid cartilage on the involved side. The pain is always located over the hyothyroid membrane on the affected side and radiates upwards to the jaw and sometimes to, or behind, the ear. There may be some pain down the side of the neck, over the thorax and even to the shoulder. The paroxysms of pain are brought on by swallowing food or saliva, by touching the trigger zone over the hyothyroid membrane, and also by stretching the neck muscles as in coughing or yawning. These attacks of pain may be fleeting, or may last for a minute. Their severity may be realized from the manner in which the patient covers the neck and jaw with his hands, holds his breath and exhibits agonizing distress by his facial grimacing. Pressure over the hyothyroid membrane or probing of the mucous membrane above the pyriform sinus will excite an attack of pain.

Neuralgia of the glossopharyngeal nerve may be easily and quickly ruled out, as in this condition the pain is over the tonsillar area and is referred directly to the ear. The trigger zone is located in the tonsillar fossa, and stimulation of this region will bring on the attack of pain. In

Read before the Florida Society of Ophthalmology and Otolaryngology, Ninth Annual Meeting, St. Augustine, April 11, 1948.

trigeminal neuralgia the distribution of pain and the trigger zones are not in the same location. Tuberculosis of the larynx, tabetic crises, laryngeal perichondritis, thyroiditis, neoplastic growths and foreign bodies in the larynx may be eliminated by the objective findings.

TREATMENT

As the act of swallowing is so extremely painful and almost impossible, there is very rapid dehydration and loss of weight. It is therefore imperative that treatment be instituted at once that will alleviate the pain. A section of the nerve may be done, or it may be injected. It is thought that direct injection of the nerve is the simplest and safest method of producing relief, with use of the method first described by Hoffmann[10] in 1908. The patient lies on the table with a small pillow placed beneath the shoulders to put the neck on a stretch, and the head is turned away from the side to be injected. The skin is prepared with green soap and alcohol, and the painful trigger zone is located by pressure over the hyothyroid membrane. This zone is marked with a spot of mercurochrome, and a 20 gauge needle is inserted to a depth of 1 to 2 cm. at a right angle to the skin. If the needle is in the proper position, moving it slightly will elicit sharp pain. The patient is then warned not to move, cough or swallow, and a small amount of a 1 per cent solution of novocain is slowly injected. If the needle tip is near the nerve, pain will cease immediately. Then without moving the needle, the syringe is charged, and approximately 2 cc. of 95 per cent alcohol is introduced. Successful blocking brings relief for several weeks, several months and often permanently. The injection may be repeated if the pain returns.

The injection of alcohol may be followed by complications and should be carried out with extreme care and certainty that the injection will be made into or near the superior laryngeal nerve and not blindly in its general direction. Koerth, McCorkle and Hill[11] noted difficulty in swallowing lasting from two to five days. They believed that this motor disturbance was due to the fact that the external branch of the superior laryngeal nerve helps form the laryngeal plexus which supplies the constrictors of the larynx. In one of their cases there was a paralysis of the lips on the left side and the left half of the tongue, which passed away in five days. Villard[12] observed the syndrome of Bernard-Horner following alcohol injection, and Klestadt[13] reported a partial facial paralysis.

REPORT OF CASE

Mr. S. L. S., aged 45, consulted me in May 1937 giving a history of slight elevation of temperature and feeling of general malaise during the preceding week. He had been seen by a physician who, without examination of the blood, made a diagnosis of malaria and prescribed atabrine. After taking the atabrine for three days he became jaundiced and discontinued it. About this time, he noticed a dull aching in the right side of the neck below the angle of the jaw. Examination of the throat gave entirely negative results except for slight redness and irritation of the mucous membrane of the posterior pharyngeal wall. His condition was thought to be a mild pharyngitis, and palliative treatment was given. At the time of his return, two weeks later, he had lost 24 pounds and presented the appearance of being in extremely acute distress. Swallowing, even of water, was almost impossible, and the paroxysms of severe laryngeal pain had prevented rest.

Examination revealed an entirely normal pharnyx. The uvula rose in the midline, and the gag reflex was present. Probing of the tonsillar region on the right side produced no pain. The larnyx was normal, and the cords functioned normally. A very slight touch over the hyothyroid membrane on the right side caused a severe paroxysm of pain lasting for about thirty seconds. General physical examination, urinalysis and Kahn test gave negative results. The internal branch of the superior laryngeal nerve was injected, on the right side, using 1 per cent novocain. This treatment brought about immediate, dramatic relief, and the patient asked for and drank several glasses of water. He was admitted to the hospital and four hours later the pain returned. The following day injection was again carried out with novocain and 95 per cent alcohol. There was some pain for ten hours afterwards and then it suddenly stopped. At the present time, ten years later, there has been no recurrence. No complications followed the injection of alcohol.

SUMMARY

Neuralgia of the superior laryngeal nerve is rare, there being only 18 authentic cases previously reported, but it is such an extremely painful condition that immediate and proper treatment is demanded.

A case is reported in which there has been no recurrence over a period of ten years.

Etiology is discussed, although no definite cause is known. It would appear that infections in the pyriform sinus and virus infections are causative factors.

The clinical findings are pain upon pressure over the hyothyroid membrane and difficulty in swallowing.

It must be kept in mind that the injection of alcohol into the neck cannot be done with impunity, and when there might be any question as to the technic, it would probably be advisable to section the nerve.

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The Present Management of Nonspecific Urinary Infections

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PENSACOLA

No single drug has been discovered which exerts a bactericidal action against all organisms which invade the urinary system. A urinary antiseptic which kills a particular organism in one person may fail to affect the same organism in another. During the past decade, however, revolutionary changes have taken place in the treatment of urinary infections. This has become the era of chemo-antibiotic therapy in which specific bacteria are attacked with specific drugs. Previously, treatment had been almost entirely empirical.

In order to obtain optimum results in the treatment of urinary infections, certain diagnostic essentials must be considered. The diagnosis of urinary infection in the female should be made only from catheterized specimens, since voided samples may be contaminated by purulent discharges from the cervix and vagina and the adjacent glands. Infections in the urethra, prostate, and seminal vesicles in the male produce discharges obtained in the first portion of voided urine. Only the second portion of the "two glass test" will, therefore, give reliable information. The specimen of urine should be centrifuged and the supernatant portion tested for hydrogen ion concentration, albumin and sugar. Microscopic examination of the "wet" sediment is studied for the presence of erythrocytes, pus, crystals, yeast and Trichomonas. A smear of the sediment is made. This is fixed with heat and stained with methylene blue. Examination of the stained smear under oil immersion lens establishes the infection as coccal or bacillary. Culture of the urine in order to detect the more resistant strains of organisms should be done when the infection has been resistant to previous therapy or when response to treatment is not prompt and effective. Study of the urea-splitting qualities of the bacteria should be carried out when the urine is persistently alkaline or if recurrent urinary calculi are being formed. Acid-fast stains must be made in all suspected cases of tuberculosis of the urinary system, or when the stained sediment shows pus without organisms.

The efficacy of urinary antiseptics is determined largely by the ability of the kidneys to eliminate the drug. Kidneys that are incapable of concentrating urine are likewise incapable of concentrating drugs in sufficient amounts to kill organisms. Knowledge of renal function is, therefore, of utmost importance. The phenolsulfonthalein test is easily made and is a very satisfactory kidney function test in the average case. A specific gravity of 1.024 or above after the patient has been dehydrated for eighteen hours, or any specimen which has a specific gravity of 1.020 or higher in the absence of glycosuria, may be accepted as evidence of normal renal function. When renal function is reduced, blood nonprotein nitrogen, creatinine, and carbon dioxide combining power determinations may be carried out, thus affording additional information as to the functioning capacity of the kidneys.

Read before the Bay County Medical Society, Panama City, March 3, 1948.

Many urinary infections have as a primary cause an element of obstruction. Any impedance to the flow of urine results in stagnation, which allows a fertile medium for the growth of micro-organisms. Stones, tumors, prostatic obstruction, chronic inflammatory changes and congenital anomalies of the urinary tract are common causes for failure of treatment with the urinary antiseptics which are employed. Such mechanical factors should be eliminated before or during the use of chemotherapeutic or antibiotic agents.[1a] Failure to remove these obstructions allows a recurrence of the infection with the possible development of bacterial resistance to the drugs and, consequently, failure of drug therapy. Complete radiographic studies of the urinary tract are desired in all cases of urinary infections to detect the presence of some obstructive factor. In cases that do not clear up promptly under appropriate therapy, it is imperative that roentgen examination be made. A scout film and excretory urograms are first carried out. If supplementary information is desired, cystoscopic examination, tests for differential renal function, ureteral catheterization and bilateral pyelo-ureterograms should be done. Foci of infection may act as contributing factors to infections of the urinary system, and the urinary infection may not be permanently cleared until such foci are eliminated. The teeth, tonsils, sinuses, gastro-intestinal tract, prostate, seminal vesicles and cervix must be eliminated as sources of urinary infection.[1b,2,7]

SULFONAMIDES

In 1937 the sulfonamide drugs were introduced into this country and were immediately applied to the treatment of urinary infections. Sulfanilamide was the first one of this family of drugs to be used clinically. At the present time, however, its use is almost exclusively limited to local application. Sulfathiazole, sulfadiazine, sulfacetimide and sulfamerazine have received wide application, and all have proved useful in the treatment of urinary infections.[8-15] When the patient does not respond to or does not tolerate one form, others should be tried. Sulfathiazole is characterized by rapid absorption and quick action; however, it does not maintain therapeutic bactericidal levels as long as sulfadiazine. Sulfadiazine is absorbed relatively slowly by the gastro-intestinal tract, is slowly eliminated and thus sustains a higher blood level. Sulfadiazine and sulfathiazole are more effective against coccal infections. Sulfacetimide is of greater value in bacillary infections. Sulfamerazine is more slowly absorbed and more slowly excreted than the other sulfonamides. My associates and I have found it useful when less frequent and smaller doses over a long period of time are indicated, as in low grade pyelonephritis complicating pregnancy. Low dosage in sulfonamide therapy is entirely adequate for the treatment of most urinary infections. The percentage of cures is as high when divided daily doses of 2 Gm. of the drug are given by mouth as when larger doses are used. The sodium salt of sulfathiazole is often well tolerated when other sulfonamides are not and is effective when 1 Gm. daily is administered by mouth. Recently, it has been shown that in certain cases of infection of the urinary tract treatment with sulfathalidine and sulfasuxidine is effective; they act principally to reduce the bacterial contents of the intestinal system, thus indirectly attacking the urinary infection.[16,17]

The frequency of complications following the use of sulfonamides in the treatment of disease of the urinary tract demands serious consideration. Indiscriminate use of these otherwise useful drugs is a dangerous procedure. Urinary suppression and anuria are not rare and are by far the most serious of the complications encountered. The nonobstructive type of suppression is attributable to a toxic injury of the renal tubules, lower nephron nephrosis. Fortunately, it is rare, as little is known concerning its prevention. We have observed that suppression occurs more frequently in patients who have had previous sulfonamide therapy. This may be due to glomerulonephritis resulting from hypersensitivity to the drug.

The mechanism of the obstructive form of anuria and the methods for its prevention have been the subject of much study and discussion.[18-36] Crystallization probably first occurs in the convoluted tubules of the kidneys. Aggregation of crystals occurs in the terminal portion of the collecting tubules, which then become filled with crystals. Further crystallization may occur in the calices and renal pelvis and also in the ureters.

The treatment of urinary suppression is generally conservative. We successfully employed intravenous isotonic sodium sulfate in several cases and found that it has a rapid and profound

effect on the re-establishment of urinary output. Additional infusions of glucose and Ringer's lactate solutions should be given if the patient is unable to retain fluids by mouth. Total fluid intake should be limited to 3,000 cc. daily in adults. Abdominal distention is an early and significant symptom in many of these cases. Decompression of the stomach and gastric lavage with saturated solution of sodium bicarbonate will materially aid in combating uremia and acidosis.

Cystoscopic examination and ureteral catheterization are important, both as diagnostic and therapeutic procedures. A roentgenogram of the kidneys, ureters and bladder taken with catheters placed in the ureters will aid in excluding the possibility of the urinary suppression being due to obstruction by true urinary calculi. Excretory urography is valueless in this condition as the kidneys can not excrete the contrast medium. Retrograde pyelography is contraindicated as it may further suppress urinary output. Lavage of the renal pelvis with alkalinizing solutions, preferably sodium bicarbonate, will often dissolve the precipitating crystals. Additional urinary alkalinization may be attained by oral, tubal or parenteral administration of sodium bicarbonate solution. Too vigorous treatment with alkalinizing solutions may be dangerous.

During administration of sulfonamides reduction of crystallization is accomplished by (1) low doses of sulfonamides, (2) increasing the volume of urine by additional fluid intake, (3) alkalinization of the urine and (4) the use of sulfonamide mixtures. As stated previously, smaller doses of sulfonamides are equally as effective as relatively larger doses. Fluid intake of at least 3,500 cc. daily is desirable. Administration of sodium bicarbonate, sodium citrate or other appropriate alkalinizing agents is advisable when sulfonamides are administered.

It has been recently observed that when a mixture of two or more sulfonamides is present in the body fluids, they will have an additive bactericidal effect, but they will dissolve almost independently.[37-39] Furthermore, a mixture of three sulfonamides, sulfadiazine, sulfathiazole and sulfamerazine, has been demonstrated to be significantly less toxic than one of these drugs administered alone.

PENICILLIN

Penicillin has been used with considerable success in the treatment of staphylococcal urinary infections, and it has proved valuable in certain cases of streptococcal infections.[10,11] It is certainly the drug of choice in sulfa-resistant coccal infections, with the exception of those infections due to Streptococcus faecalis. It should be emphasized that penicillin is of little value in bacillary infections and is useless in tuberculosis of the urinary tract.

The usual dosage of penicillin is 25,000 to 30,000 units intramuscularly every three hours until the infection is controlled. Higher doses may be indicated in severe infections. With the administration of penicillin the urine should be acidified as the bactericidal action of this drug is increased in an acid medium. The efficacy of penicillin may be enhanced by the administration of sulfonamides.[12-14] This phenomenon may be due to a synergistic action between the two drugs. The beeswax in oil preparations of penicillin are now widely employed in office and outpatient treatment. Not infrequently, however, the patient experiences a sensitivity reaction to the mixture. Also multiple injections of this preparation are rather painful at times. Recently, we have employed a combination of penicillin, novocaine and oil and find it to be very effective and practically painless. In our experience oral doses of penicillin are not as effective as parenteral administration. Reactions to penicillin are principally allergic in nature. Rarely, urticaria, drug fever, headaches, pains in the joints or "serum sickness" will develop.[45-47]

STREPTOMYCIN

Streptomycin was first applied clinically in 1944 and was found to be particularly efficacious in the treatment of urinary infections.[48-54] It has a specific bactericidal action against the colon bacillus. It is effective in treatment of infections due to Streptococcus faecalis, Bacillus pyocyaneus, Bacillus proteus, Bacillus lactis aerogenes and certain strains of the mycobacterium of tuberculosis. It is often valuable, therefore, in infections that are resistant to penicillin, the sulfonamides and other bactericidal agents. Hence, in mixed infections which have been resistant to previous therapy, best results may be obtained by combining streptomycin, penicillin and the sulfonamides. All of these drugs are compatible.

Streptomycin is usually administered by intramuscular injections, but may be given subcutaneously. There is a strong tendency for streptomycin resistance or fastness to develop in many initially sensitive organisms. It is impera-

tive, therefore, that large initial doses be given in an effort to eradicate the infection before resistant strains develop. A minimum of 3 Gm. daily, in divided doses, every three hours is preferred in adults, and in children relatively smaller doses. The antibacterial activity of streptomycin is much higher in an alkaline medium. Alkalinization also reduces the likelihood of the development of streptomycin fastness in the infecting organism. Thus, alkalinization of the urine is desirable when streptomycin therapy is in progress. An exception to this is when urea-splitting organisms are present.

Reactions to streptomycin have been few and are relatively benign. There are two notable exceptions. Vestibular disturbances not infrequently occur following administration of the drug over a prolonged period of time. Also cases of deafness, temporary or permanent, have been reported. Following administration of streptomycin there is usually some drop in blood pressure. In a few patients, we have observed a decided and precipitous fall in blood pressure, as much as 50 mm. of mercury. This drug should, therefore, be used with great caution in elderly patients with hypertension.

ARSENICALS AND MANDELIC ACID

Neoarsphenamine was probably the first specific drug used in the treatment of coccal urinary infections, and despite the advent of numerous newer drugs, arsenicals administered intravenously still have a place in the treatment of this type of infection. Recently, renewed interest has been shown in the treatment of amicrobic pyuria with arsenicals.[55-57] We have found that three or four injections of neoarsphenamine or mapharsen usually suffice. They are used much in the same manner as in treating syphilis, and the usual precautions regarding renal function should be observed.

Mandelic acid and its derivatives are efficient in the treatment of bacillary infections of the urinary tract and are almost specific in the treatment of infection caused by Streptococcus faecalis.[58,61] When this organism is present, mandelic acid often will clear the urine when the newer drugs have failed. We have successfully employed methenamine mandelate when bacteriostasis must be carried out over a long period of time. Fluids are restricted and alkalinizing drugs are omitted when a considerable degree of acidification of the urine is being attained. Toxic reactions to mandelic acid and derivatives are slight and infrequent.

SUMMARY

An adequate clinical and bacteriologic evaluation is essential in the treatment of urinary infections. Removal of any obstruction which impedes the free flow of urine is essential for the full therapeutic benefit derived from chemical or antibiotic agents.

Generally, relatively small doses of sulfonamides are adequate for treatment in most cases of urinary infections. The combination of multiple sulfonamides is more efficient and is not accompanied by any increase in renal complications.

Penicillin is of greatest value in the treatment of coccal infections. It is of little value in bacillary infections and is useless in tuberculous infections. Streptomycin is valuable in the treatment of infections due to gram-negative bacilli and has value in the treatment of genito-urinary tuberculosis. Adequate dosage of antibiotic agents should be instituted in order to preclude possible resistance to these antibiotics. The combined use of antibiotics and chemotherapeutic agents may be indicated in mixed infections. Untoward sequelae resulting from therapy with these drugs should be carefully sought for, and precautions should be taken to prevent them.

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Pericardial Celomic Cyst: Case Report

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and
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St. Petersburg

Thin-walled cysts located in the mediastinum adjacent to the pericardium have been designated pericardial celomic cysts by Lambert,[1] who in 1940 reported 2 cases he had seen along with 2 other cases from the literature. It is supposed that, due to some slight defect in the breakdown of the various lacunas in the primordial mesoderm that go to make up the pericardial celom, there remains one or more loculations of the pericardial celom near the main pericardial sac and that these rarely persist through embryonic development and appear as cystic masses during life. These cysts are thin-walled, lined with a low epithelium and usually contain a thin fluid, most often clear but occasionally sanguineous. Lam[2] in 1948 reported a case of his own and mentioned the 4 cases quoted by Lambert.[1] These cysts are undoubtedly more common than reports indicate and probably have been reported previously under other designations. Churchill[3] reported a simple cyst of the mediastinum which has most of the characteristics of a celomic cyst. Greenfield, Steinberg and Touroff[4] also reported a cystic mass of the anterior mediastinum as a "spring water" cyst and from the gross microscopic report it does not seem to be essentially different from this group. Its frequency must be of a low order, however, as in nearly 4,000 fluoroscopic examinations of the chest in selected cases in a large general hospital, normal-appearing chests having been screened out on previous roentgen examination, no case was seen which fulfilled the relatively simple criteria. Abbott[5] of Atlanta has seen 14 such cases which are unreported as yet.

The radiologic differential diagnosis of mediastinal masses is as follows:[6,7,8]

"The tumors are usually:

I. Cystic in character.
II. Connective tissue.
III. Malignant tumors.
IV. Metastatic tumors.
V. Aneurysms and other masses.

I. The cystic tumors:

A. Pericardial cysts are mesodermal in origin. The pericardial cysts are usually circumscribed, well encapsulated, homogeneous masses, and are always associated with the pericardium. Definite elongation of the tumor on inspiration and flattening on expiration is a differentiating point of this tumor as seen on fluoroscopic examination.

B. The dermoids and the teratomas are unable to be differentiated from each other by x-ray. They are circumscribed, well encapsulated and usually located on the anterior superior mediastinum. They may contain certain portions of bone and teeth.

C. The lymphangiomas are irregular in shape, not encapsulated, and are usually located in the retrocardiac space in the hilum, usually on the left.

D. The echinococcal cysts are circumscribed, well encapsulated, usually located near the hilum and are frequently diagnosed by the lesion elsewhere.

E. The bronchial cysts. About 50 per cent of these have fistulous openings. They are located above or at the bifurcation of the trachea. These tumors are located in the midline, posterior to the trachea and esophagus, anterior and to the left of the upper dorsal vertebrae.

F. The esophageal cysts may be located in any portion of the esophagus but are usually in the middle third. The cysts in the upper portion of the esophagus have the same radiographic appearance as bronchial cysts.

II. Some of the connective tissue tumors include:

A. Neuroma or neuroblastoma which are derived from the posterior ganglia, intercostal nerves or the sympathetic nerv-

Read before the Pinellas County Medical Society, March 4, 1948.

ous system. These tumors are usually dense, nodular and circumscribed. The foramina and a portion of the body of the vertebra may show bone destruction. They are always located in the paravertebral space.

B. Fibromas are circumscribed, dense, well encapsulated and usually located in the anterior mediastinum near the pericardium. They do not pulsate or change in size and shape on respiration.

C. The lipomas are encapsulated, usually associated with the costal spaces or through the pleuroperitoneal Foramen Bachdaleks in the anterior mediastinum by a pedicle closely associated with the pericardium. They are homogeneous in density but more dense in the center.

D. The chondroma is a circumscribed, homogeneous tumor of varying size. These tumors are derived from the rib cartilages anteriorly or from the cartilages of the dorsal vertebrae. These tumors are usually located in the anterior mediastinum.

E. Thymoma are irregular, dense, homogeneous masses, usually located in the anterior superior mediastinum.

III. Malignant tumors:

A. The sarcoma may be located anywhere in the thoracic cavity, and cannot be differentiated by x-ray except through elimination.

B. Malignant lymph node tumors include the lymphoblastoma and lymphatic leukemia. These tumors are usually large, irregular in shape and located superior to the pericardium. The x-ray differential diagnosis can be made by small doses of x-ray therapy. These lymphatic tumors are very radiosensitive, but the lymphoblastoma (Hodgkins' Disease) are usually radioresistant.

C. Carcinoma.

1. The bronchogenic carcinoma is usually located in the primary and secondary bronchi and may be irregular, infiltrating and varying in size and shape, with usually associated bronchiectasis, atelectasis, and pneumonitis due to compression of the bronchi.

2. Endothelioma of the pleura (Pancoast Tumors) are nearly always located in the apices, and many show infiltrating characteristics.

IV. Metastatic tumors:

A. Solitary metastatic lesions usually show the primary lesion in other parts of the body.

V. Aneurysms and other masses:

A. Aneurysms cannot be dissociated by fluoroscopic examination from the vessels. Many contain calcification and erode bone if close to the sternum or vertebrae. They usually pulsate. Angiocardiography will, in most cases, offer considerable help in differential diagnosis.

B. Diaphragmatic hernias are diagnosed by study of the barium meal and pneumoperitoneum.

C. Pneumonitis consolidation and atelectasis are usually differentiated by clinical history and waiting.

Nearly all the interthoracic tumors should be fairly correctly diagnosed by x-ray including angiocardiography, diagnostic pneumo-thorax, pneumoperitoneum, and accessory assistance, such as bronchoscopy, thoracoscopy and aspiration biopsy. There is no contraindication to aspiration biopsy with the exception of echinococcal cysts."

REPORT OF CASE

J. C., a white man aged 37, had two survey roentgenograms of the chest, one in June 1946 and the other in July 1947. He was informed of the finding of a mass in his chest and was referred for examination. A history of fatigue and a 12 pound loss in weight during the past eighteen months was elicited. Palpitation and slight dyspnea had also been noted during the past few weeks. A peculiar noise on breathing while in the recumbent position was noted. There was difficulty in evaluating symptoms completely as the patient was much upset by the roentgen report. He was referred for a full size radiographic study in all positions. The preoperative roentgenograms are shown in figure 1.

The following fluoroscopic report was given:

Fluoroscopic examination (Aug. 30, 1947) of the chest reveals no tracheal displacement. The diaphragms are of normal position, size and movement. The heart is of normal position, size and pulsation. In all views there is a mass in the lower right chest, anteriorly and medially situated. This mass has a smooth, rounded, sharp border. It cannot be separated from the pericardial shadow in this region of the right atrioventricular junction, but this does not imply that it is a part of, or attached to the pericardium. On respiration, there is some downward movement simultaneous with the movement of the right diaphragm and there is some apparent elongation of the mass as it is stretched vertically. There is no pulsation in the mass. Impression: Extra cardiac mass in the right chest. Possible: 1. Pericardial cyst. 2. Benign cyst close to the pericardium. 3. Teratoma. 4. Neurofibroma.

This patient was referred to Dr. Osler Abbott of Emory University in Atlanta. The history was essentially as given. The physical findings were essentially negative

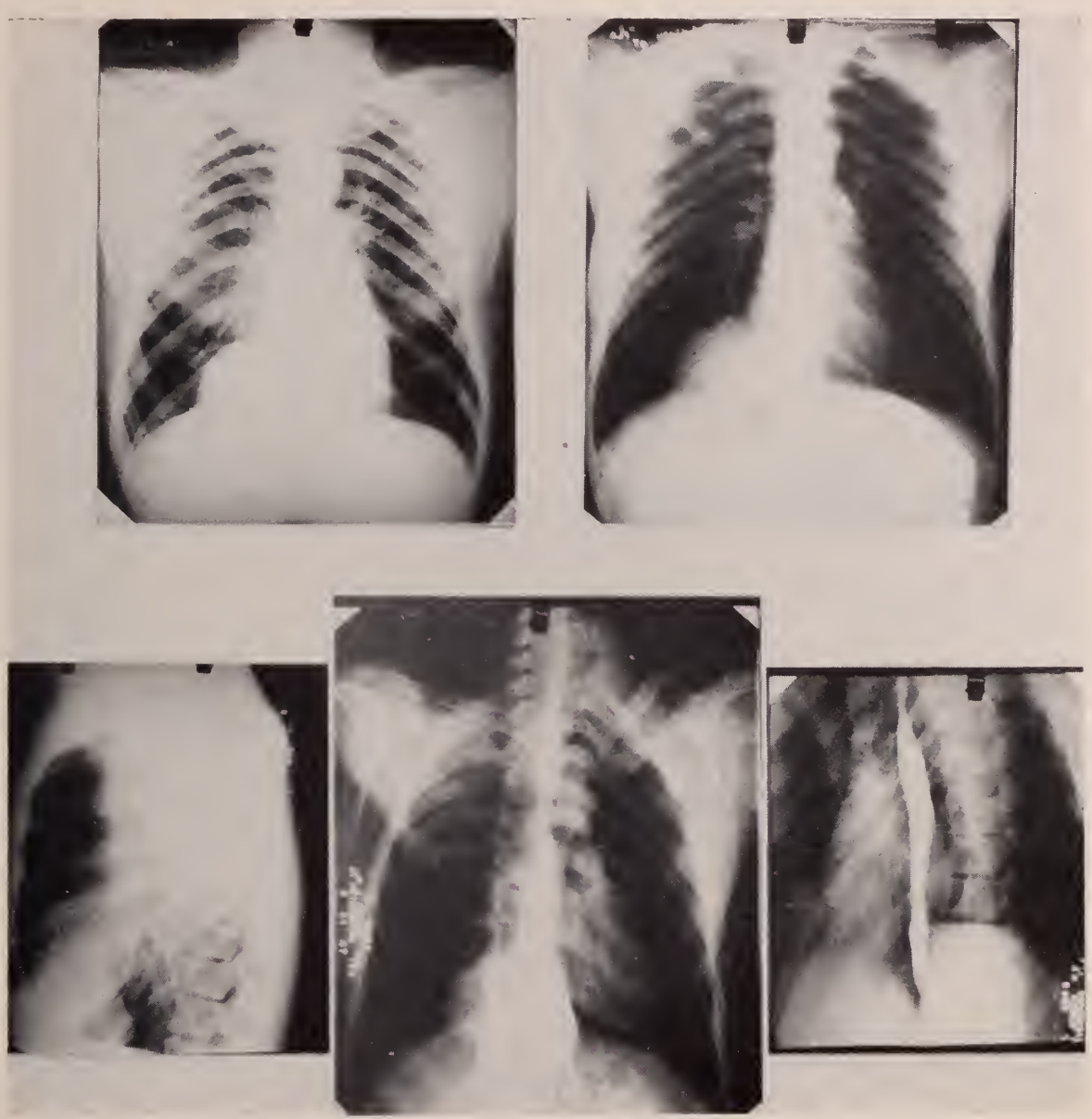


Fig. 1.—Radiologic study, August 1947. Exactly posterior-anterior view, ordinary technic; anterior-posterior view with greater penetration; left lateral; right and left anterior oblique views with barium in the esophagus. All show a rounded, dense mass in the right side of the chest located inferiorly, medially and anteriorly. See fluoroscopic report in text.

except for some increase in percussion dulness of the right lower cardiac border. Laboratory findings were normal.

Following penicillin therapy, the patient was operated on. Intratracheal gas-ether-oxygen was used after pentothal sodium induction. A large, thin-walled cyst, about the size of an orange, filled with thin, clear fluid, was found between the mediastinal pleura and the pericardium overlying the right atrium. This cyst was attached posteriorly by a thin stalk, anterior and medial to the inferior vena cava and posterior to the pericardial sac. Complete removal was accomplished and the chest closed. Portions of the middle lobe and inferior lobe, which were atelectatic from pressure of the mass, were re-expanded. Daily chest taps were done postoperatively, and convalescence was uneventful.

The pathologist reported the specimen as membrane of a cyst wall, composed of a thin layer of fibrous tissue lined with a low epithelium. No inflammatory or neoplastic changes were noted.

The patient is in good health and back at work. Postoperative roentgenograms are shown in figure 2.

SUMMARY

Pericardial celomic cysts probably occur more frequently than is generally supposed.

The radiologic differential diagnosis of mediastinal masses is presented in detail.

A case of pericardial celomic cyst is reported.

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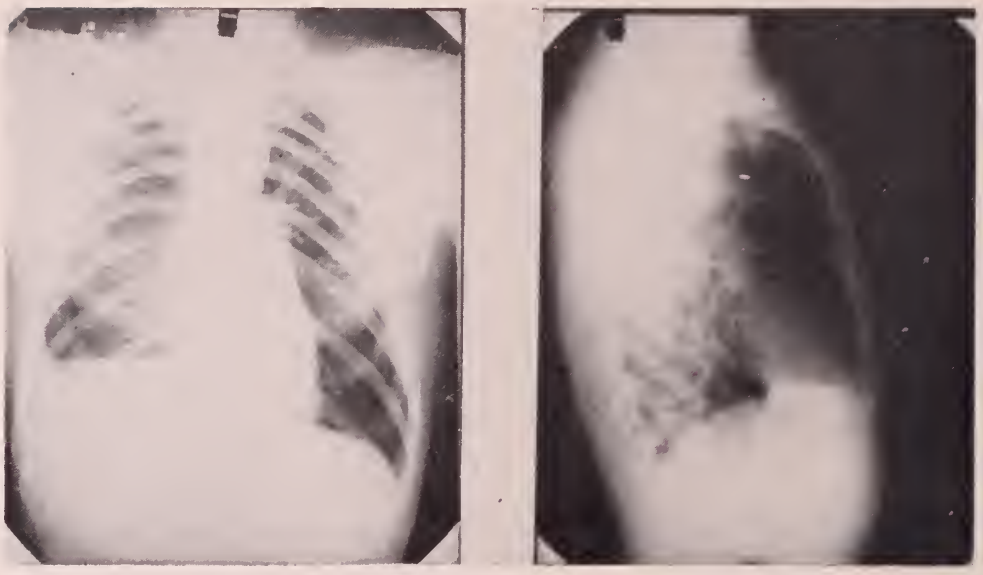


Fig. 2.—Exactly posterior-anterior view and right lateral view, Oct. 21, 1947, seven weeks postoperatively.

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ABSTRACTS OF MEDICAL ARTICLES

A SYSTEM OF DIABETIC DIET PRESCRIPTION FOR THE GENERAL PRACTITIONER. By Carlos P. Lamar, M.D. Am. J. Digest. Dis. 14:323-332 (Oct.) 1947.

The author presents four basic or standard diabetic diet prescriptions which depart from the use of unnecessarily complicated calculations. He has endeavored to build his system from the formula of a normal menu, to fit it to the patient's needs and to preserve for the diabetic patient the enjoyment of good and pleasant food.

Diets 1 and 2 were designed by the author to provide for weight reduction; diet 3 is calculated for moderate caloric needs, and diet 4 is arranged for average needs. For larger requirements, the prescriptions are so arranged that unlimited variations and increases may be made with simple additions.

The system provides the physician with a wide choice of basic formulas with which to suit his patient's needs. The author recommends that the patient be given a complete set of the simple instructions and also the menus for each meal, which provide a wide choice of variations and portions easily measured without the need of intricate tables or of weight scales. The patient is instructed to use a measuring cup, measuring spoons and a six-inch washable plastic ruler as his equipment.

ANAPHYLAXIS AND ANESTHESIA. By Harold Carron, M.D. Anesthesiology 8:625-636 (Nov.) 1947.

The author believes that no generalizations can be made regarding the protection offered against anaphylaxis by anesthesia. Following experiments with mice and guinea pigs, he concluded that ether anesthesia does not prevent anaphylactic shock in unpremedicated mice, but it apparently affords some protection against anaphylactic shock in unpremedicated guinea pigs, particularly in actively sensitized animals. In the experimental mice, he found that ether apparently enhances the manifestations of anaphylaxis and decreases the survival time following injection of the shocking dose of serum.

Cyclopropane anesthesia did not prevent anaphylactic shock in unpremedicated mice or guinea pigs. It decreased the survival time of the guinea pigs injected with a shocking dose of serum, but apparently had no effect on the intensity of the shock or the survival time following injection of such a dose in the mice.

These experimental studies led to two conclusions: (1) that the sympathomimetic action of ether anesthesia is of value in the prevention of anaphylactic shock in those animals in which the manifestations of anaphylaxis are predominantly pulmonary, and (2) that the inhibition of anaphylactic shock is not a property of anesthetic agents in general.

An extensive review of the literature on nonspecific inhibition of the anaphylactic syndrome is given.

ALLERGIC NEURODERMATITIS. By Clarence Bernstein, M.D. Urol. & Cutan. Rev. 49:684-687 (Nov.) 1945.

Six cases are presented for the purpose of pointing out the striking interplay of anxiety nervous tension states and allergic skin disorders as they are met in office practice. These cases have features common to both the purely allergic segment of the dermatoses and the neurotic. The lesions in the skin are characterized by itching, punctiform vesicles, erythema, edema and occasional exudation; they occur in such variable locations as the hands, arms, legs and feet, and about the face and eyes.

Psychogenic and allergic factors uncovered have both been considered etiologic factors. Treatment based on both considerations has given relief more promptly to the patient. Allergic neurodermatitis is preferred as the appropriate term for this lesion. Possible mechanisms are discussed.

THE FLIGHT SURGEON: HIS ROLE IN STUDENT PILOT TRAINING. By Richard C. Cumming, Col. M.C., A.U.S. Mil. Surgeon 100:385-389 (May) 1947.

The role of the flight surgeon with its varied human interest aspects is graphically set forth in this account of the experience of the author with student pilots of several nationalities as he

participated in their training program over a period of more than five years. There first came under his care at the Lodwick School of Aeronautics at Lakeland 1,560 cadets, of whom 986 were British and 574 American. Later, his work was with the 1,660 Negro cadets at the Tuskegee Army Air Field, Tuskegee, Ala. To all of these student pilots he pays high tribute. He observed that regardless of climate, age or race, from the surgical viewpoint the various groups presented the same problems, but the percentage of operations for cadets was low compared to that for enlisted men and pilots. Serious accidents were few, but spectacular. The highlights of some of the unusual accidents that may claim the flight surgeon's attention are presented.

NEUROSYPHILIS AS SEEN BY THE INTERNIST: DIAGNOSIS AND PRESENT-DAY EVOLUTIONARY THERAPY. By Clarence Bernstein, M.D., and Solomon D. Klotz, M.D. Urol. & Cutan. Rev. 51:200-203 (April) 1947.

This article re-emphasizes the protean manifestations of syphilis, particularly neurosyphilis, and the need for early detection of syphilis of the central nervous system. Four cases which represent a fair sampling of the type of clinical material seen by the internist are reported. Some phases of the treatment of neurosyphilis are discussed with special reference to penicillin and fever. It is pointed out that the combined treatment yields better clinical results than either method alone.

MALIGNANT MELANOMA OF THE NASAL MUCOSA. By Charles C. Grace, M.D. Arch. Otolaryng. 46: 195-210 (Aug.) 1947.

A case of malignant melanoma of the nasal mucosa is reported and is believed to be the first one recorded in which this rare lesion in this location occurred in a Negro. The literature on this unique tumor, which develops in a site where the tissues normally do not contain pigment, is reviewed, and the 66 collected cases are analyzed with respect to sex, age, duration and nature of symptoms, site within the nasal cavity, treatment and prognosis. In some cases the primary tumor remains localized over a long period. Its slow growth as compared with the rapid dissemination of the metastatic lesions is an important consideration in treatment, emphasizing the importance of radical removal including a wide margin of normal tissue. The prognosis is grave; in only 3 cases was there a record of survival without recurrence or metastasis for more than two years.

EFFECT OF VARIOUS SOLUTIONS OF PENICILLIN SODIUM AND PENICILLIN CALCIUM ON THE RESPIRATORY NASAL MUCOSA OF RABBITS. By Noah D. Fabricant, M.D., A. R. Hollender, M.D., and Harold W. Anderson, M.D. Arch. Otolaryng. 46:36-39 (July) 1947.

From their animal investigations and from clinical reports in the literature, these authors concluded that penicillin solutions administered topically have no deleterious effect on respiratory nasal membranes. Their studies demonstrated that various solutions of sodium and calcium penicillin (containing from 1,000 to 5,000 units per cubic centimeter) when applied topically to the respiratory nasal mucosa of rabbits every day for thirty to ninety days have an apparently innocuous effect on nasal tissues. Penicillin solutions suitable for topical application in the treatment of nasal and sinal infections are, it seems, compatible with ciliary activity, have a slightly acid hydrogen ion concentration value approximating that of normal nasal secretions, are isotonic and are noninjurious and nontoxic.

OBSERVATIONS ON PITYROSPORUM OVALE IN SEBORRHEIC BLEPHARITIS AND CONJUNCTIVITIS. By Joseph S. Gots, M.S., Phillips Thygeson, M.D., and Morris Waisman, M.D. Am. J. Ophth. 30:1485-1494 (Dec.) 1947.

Although Pityrosporum ovale is the only constant bacteriologic finding in seborrheic dermatitis of the eyelids, the role of this unclassified yeastlike organism in the disease remains unsettled, according to the authors.

They report 143 cases of clinically recognizable seborrheic dermatitis of the eyebrows and the eyelids in which in every instance P. ovale was found in scrapings. The organism was isolated in pure culture with difficulty and only on media containing fatty acid. Experimentations are difficult since clinical seborrheic dermatitis is not a natural disease in animals and

because animal inoculations with P. ovale have failed to reproduce the disease. The few human inoculations recorded have been inconclusive.

Although there is still a difference of opinion among dermatologists as to whether the role of P. ovale is pathogenic or purely saprophytic, the authors believe that the following findings are suggestive of an etiologic relationship between P. ovale and the eye and its adnexa: (1) the constant occurrence of the organism in the lesions; (2) the apparent relationship between the number of organisms present in scrapings and the severity of the clinical disease; (3) the absence of the organism, or its exceptional presence in small numbers only, in clinically normal eyes; (4) the inability of the organism, unlike most saprophytes, to grow on any but complex media; and (5) the demonstration, by intradermal skin tests, of sensitization to the organism. The study suggests that P. ovale is pathogenic for this disease, but admittedly the evidence is not conclusive.

NUTRITION AND METABOLISM OF PATHOGENIC FUNGI. By Walter J. Nickerson, Ph.D., and John W. Williams, M.D. In Biology of Pathogenic Fungi, edited by W. J. Nickerson (Annales Cryptogamici et Phytopathologici, vol. 6), Waltham, Mass., the Chronica Botanica Co., 1947, Chap. 9.

This study, with extensive bibliography, of experimental data on the nutrition and metabolism of the fungi causing disease in man covers growth on natural products and complex media, nitrogen nutrition, carbon nutrition, mineral nutrition, growth factor requirements and physiochemical factors in growth. The information gained from such a study permits comparison with numerous nonpathogenic forms that have, in many cases, been thoroughly studied, and may lead to some hypotheses, admitting of experimental test, concerning the metabolic reactions of the pathogen that might distinguish it from related nonpathogenic fungi. Thus some insight may be gained into the necessity, cause, or "reason" for the parasitic life of the pathogen and further progress towards the specific prevention or treatment of the disease caused by the pathogen.

It is shown that some of even the most virulent pathogenic fungi may be grown on very simple chemically defined media. Since all evidence indicates that the fungi causing systemic infections have a saprophytic existence in nature, it is suggested that such a situation may require a shift of emphasis away from some of the implications of the growth factor-pathogenicity work that has been so valuable with bacteria and protozoa and previously assumed to hold for the fungi pathogenic for man; corresponding increases in emphasis may be placed on other metabolic characteristics of the pathogenic fungi. For example, the authors note that the real requirement by many species of relatively high nutritional levels of certain heavy metals might bear closer scrutiny.

EAR DEFENDERS. By H. Marshall Taylor, M.D. Laryngoscope 57:137-141 (Feb.) 1947.

In this article the author outlines the progress made, particularly during the recent war years, in the development of an ear defender that would meet the exactions of military requirements. Exhaustive research by a distinguished company of scientists culminated in the development of the ear warden designated as V-51R, which is described and illustrated. This convenient and comfortable device for occluding the auditory canal is made of black neoprene and when fitted properly, inserted correctly and used routinely under suitable conditions, should lessen the hazards of temporary or permanent impairment of hearing both for military personnel and industrial workers.

EXPERIENCES WITH TRYOTHRICIN IN RHINOLOGY, SURGERY AND DERMATOLOGY. By Joseph L. Goldman, Lt. Col., MC, S. A. Roddenberry, Capt., MC, Herbert E. Fitch, Jr., Capt., MC, and Morris Waisman, Capt., MC. Ann. Int. Med. 27:103-113 (July) 1947.

Although tyrothricin does not possess the broad application of penicillin because it cannot be administered systemically, this drug has in the opinion of these authors a definite place in the treatment of surface infections. They present three types of cases treated with tyrothricin locally, namely, rhinologic infections, surgical infections and dermatologic infections.

In the rhinologic group, the drug was used in the treatment of sinus infections, in the direct and prophylactic treatment of postoperative sinus wounds and sinuses, and in the prophylactic treatment of acute coryza to prevent or reduce the severity of the suppurative stage. In the surgical group, it was used in a series of pilonidal cases and in a series of minor surgical infections. In the dermatologic group, it was employed in a series of resistant infections.

The concentration of tyrothricin used in these cases was 0.2 mg. per cc. (1:5,000); that is, 1 cc. of a 2 per cent alcoholic solution of tyrothricin was added to 100 cc. of distilled water.

In this study tyrothricin was found to be an effective antibiotic in controlling and preventing surface infection.

CARCINOMA OF THE THYROID GLAND IN CHILDREN. By Julian A. Rickles, M.D. Am. J. Surg. 74:8-13 (July) 1947.

Four cases of carcinoma of the thyroid gland in children between the ages of 6 and 11 years are reported, and a discussion of diagnosis and treatment follows. In the first case, simple excision of the adenoma, present most of the patient's life, apparently sufficed, for three years had elapsed without recurrence or evidence of metastasis. This case illustrates, the author pointed out, that the only difference between a benign and a malignant adenoma of the thyroid is the finding of the vascular invasion in the microscopic examination of the tissue.

In the second and third cases, the tumors occurred in sisters, were practically identical microscopically, and both girls had definite evidence of hypothyroidism. Total thyroidectomy was performed in both cases. The author favored deep roentgen therapy postoperatively, but it was not administered.

The fourth case illustrates the difficulty of making a clinical diagnosis in the diffuse type of malignant disease. In this instance the diagnosis was made only by microscopic examination of a metastatic node which was grossly normal. The response to total thyroidectomy and roentgen therapy was excellent.

The author concluded that the prognosis is excellent if children with this disease are treated promptly.

MONOCYTIC LEUKEMIA, A CASE REPORT ILLUSTRATING VARIATIONS IN THE CLINICAL PICTURE. By Arthur E. Rappoport, Lt. Col., M.C., A.U.S., and Victor H. Kugel, Major, M.C., A.U.S. Blood 2:332-355 (July) 1947.

In this comprehensive article with extensive bibliography the origin and characteristics of the monocytic cell are discussed, and its probable derivation from mesenchyma is emphasized. The discussion indicates the difficulty in delineating the clinical syndrome and the cytologic characteristics of monocytic leukemia. Noting that this entity has engendered a variety of divergent clinical and histologic opinions, the authors were led to believe that some of the discrepancies in the literature can be synthesized into an organically unified and acceptable concept. Study of the "natural history" of monocytic leukemia yields observations, they concluded, which tend to reconcile many of the hitherto conflicting opinions regarding the disease. They present a case in which prolonged and intensive clinical and laboratory observations demonstrate the erratic course of this disease and illustrate the erroneous conclusions that may be derived from inconstant, momentary observations of this dynamic process.

DELAYED CONVALESCENCE FOLLOWING ACUTE HEPATITIS, A CLINICAL AND LABORATORY EVALUATION. By Donald F. Marion, M.D. Gastroenterology 8:717-723 (June) 1947.

The author reviews the medical records of a representative group of 82 male patients with an average age of 26 years who were transferred to a final type Army hospital because of failure to recover completely after prolonged hospital treatment for acute hepatitis. In this delayed convalescence group, 44 per cent recovered both objectively and subjectively after prolonged and intensive treatment. An additional 44 per cent, while completely recovered subjectively, continued to show objective evidence of mild hepatic impairment. Eight per cent continued to present subjective symptoms of possible hepatic origin long after all objective evidence of dysfunction had disappeared. In 4 per cent, if the diagnosis of early hepatic cirrhosis was correct, there was probably true progression of a continuous disease to a point where complete recovery could no longer be anticipated.

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DIABETES DETECTION DRIVE
THE PHYSICIAN'S ROLE

The existence of a million undiscovered diabetic patients in the United States has been demonstrated through a series of surveys, the most recent of which was conducted by the United States Public Health Service. The results of these studies now provide an opportunity for the medical profession to seize the initiative and carry forward in this significant phase of public health.

The American Diabetes Association has planned a simple, direct campaign to promote the early discovery and prompt treatment of the million undiscovered cases of diabetes, with the physician himself in the driver's seat. Through local diabetes associations, with the cooperation of local, county and state medical societies, it is planned to carry out screening tests by a new five minute micro-blood sugar method with simultaneous urinalysis for sugar and with attention to time relation to food. The candidate will be required to name a physician or clinic to which the results of the tests will be mailed for interpretation. By this procedure the unknown diabetic patient will be brought under the care of his own physician.

This association plans to carry on an intensive educational campaign through newspapers and radio channels which should help physician and patient alike. It also will supply physicians throughout the nation with a "Handbook of Therapy" to guide the physician in the treatment of diabetes.

The week of December 6-12 was proclaimed "Diabetes Week" to serve as the formal beginning of the drive which, it is planned, will continue on a long term basis.

The American Diabetes Association seems determined to do its part, probably more than its part, in finding the million unknown diabetic patients and guiding them to the physician for treatment. It would seem that the least each physician can do is to cooperate to the fullest in this worthy project, both by giving support to the campaign and by furnishing adequate treatment for the new diabetic patients when they present themselves.

RESERVE THESE DATES
APRIL 10, 11, 12, 13, 1949
FOR THE CONVENTION IN
BELLEAIR

PEPPER—SLAUGHTER FORUM DEBATE ON COMPULSORY HEALTH INSURANCE

Florida's Senator Claude Pepper, silver-tongued orator of the Senate, and Florida's distinguished author-lecturer-surgeon, Dr. Frank G. Slaughter, chairman of the Public Relations Committee of the Florida Medical Association, met head on in a lively verbal tilt in Jacksonville on November 18 in an open forum sponsored by the Jacksonville Junior Chamber of Commerce. "Should Congress Enact Compulsory Health Insurance Legislation?" was the subject of the debate.

The nation's foremost advocate of compulsory health insurance advanced the usual arguments, long since worn threadbare, to bolster his pet scheme, declaring the compulsory plan to be "the Democratic approach to the essential problem of prolonging the life and preserving the health of the American people." In the light of the truth, it takes intestinal fortitude possessed only by the very few—especially among those expected to be responsible and intelligent representatives of the citizenry—to have the temerity to drag out again and again the creaky skeleton of 40 per cent rejections in Selective Service and with clanging oratory lay this high rate to conditions resulting from lack of medical care. Too, the sob story indictment of the medical profession, charging it with neglecting the medical needs of the people and leaving millions of low income workers without medical care, grows boring, to say the least, to any person who will take the trouble to inform himself.

With scintillating clarity, Dr. Slaughter, in refuting these claims, characterized the Senator's favorite legislative child as "a hydra-headed brat, sired by three men in the pay of the Federal Government, Altmeyer, Ewing and Falk, and designed further to regiment the American people." He was quick to remind the capacity audience and the radio listeners that the doctors of the country are giving away a million dollars a day in free medical services and are fostering nonprofit plans for prepaid medical care through the Blue Cross and Blue Shield whereby people may protect themselves. Point by point, Dr. Slaughter knocked down the Senator's straw men as he built up the case against socialized medicine, blasting into absurdities the pious claims and formidable-sounding statistics of his opponent. His brilliant rebuttal was abundantly attested by the overwhelming approval of the forum and the radio audience.

Stung by the exigencies of the moment into recanting somewhat in view of his wholly untenable position, Senator Pepper sought to mitigate his blistering accusations by suave speech and hollow expressions of personal admiration for the medical profession—an old, old story all too familiar to Florida doctors and sorry camouflage indeed for an ardent proponent of socialized medicine, by whatever name it may be called. Every thinking man of medicine must realize that any advocate, much less an aggressive champion, of governmental control of the profession brands himself as its sworn enemy.

Having stated publicly his intention to introduce before the next Congress a proposal for compulsory health insurance, Senator Pepper specifically identified it as following the familiar Wagner-Murray-Dingell line. It is no happenstance that on the day he was in Jacksonville contending against Dr. Slaughter's cogent presentation of the true situation, Dr. Arthur Altmeyer of the Social Security Board announced that not only would compulsory health insurance be proposed to the next Congress but also compulsory insurance for wage loss from sickness, the second head of proposed legislation described by Dr. Slaughter as the "hydra-headed brat." And the day following, Mr. Oscar Ewing, Federal Security Administrator, made a similar statement before a national labor group.

The physicians of America face today the most critical fight in their entire existence, the fight for survival as a free profession. The enemies of medicine, led by Altmeyer, Ewing and Falk, powerful triad in the Federal Security Administration and the Bureau of Research and Statistics, have as their spokesman one of America's finest orators, the man whose tongue is feared most of all on the floor of the Senate. His mellifluous tones promise to unwary voters a Utopia which could only be a pitfall. Not only would it wreck the health record of American Medicine and the American People, but all too soon it would engulf the nation's health and the national economy in a maelstrom of destruction from which there would be no escape.

DO YOU READ YOUR JOURNAL?

The questionnaire propounded by the Assistant Editor of The Journal at the District Meetings last October elicited information that should interest the members of the Association in general as well as The Journal's editorial staff in particular. The 111 physicians who obligingly responded to the two main questions, "Do you read your Journal?" and "What is your favorite section?" doubtless represent a cross section of the membership, and their views probably reflect the general opinion regarding the Association's official organ.

Approximately two thirds of the group read The Journal regularly. Only three physicians acknowledged reading it seldom, the remainder reading it irregularly. One fourth read it thoroughly. Nearly two thirds peruse it as they would most any magazine or journal, preferring certain sections.

With a bare majority of these physicians, the scientific articles take precedence as the favorite section. Next in favor are news items, with almost one third expressing particular interest in this feature. In fact, three times as many are particularly interested in the doings of their colleagues, it seems, as are interested in their writings, for hardly a tenth of the group prefer the abstract section. Nearly one fourth find the editorials to be of paramount interest—not too heartening a number. The commentaries appear to evoke the least interest, only five physicians ranking them as meriting special attention.

The Editors salute the lone member of the group who frankly stated that he not only has no favorite section but that he reads The Journal not at all. Also, we salute the physician who reads all sections except the scientific articles, skipping them because he is "not interested in them." Doubtless these two represent a tiny minority within the Association, but fortunately their number would seem to be relatively infinitesimal in the light of this questionnaire. And we would not fail to mention the reader who reads some sections "once, some twice and some three times." We trust the motive for rereading is sheer interest, and we commend his zeal to other readers.

After all, The Journal belongs to the members. Too, it can be no better than they make it for they are contributors as well as readers. All the members, from those who read it seldom or not at all to those who read it thoroughly, share in the responsibility for its success or failure to fill its rightful place. The Editors welcome comment, favorable or adverse, just so it is sincere and constructive. Comment of whatever nature is certainly better than none at all. Likewise, they welcome contributions of sufficiently wide interest to appeal to a fair proportion of the membership.

Do you read your Journal? How long since you have been a contributor to its columns? What are you doing to make your Journal a better publication?

FLORIDA STUDY OF CHILD HEALTH SERVICES

When the American Academy of Pediatrics undertook a nationwide study of child health services two years ago, the Florida State Pediatric Association was one of the first groups to get its study under way. The project was based on the conviction that physicians themselves should assume greater responsibility in planning medical care for children. Recently the physicians of Florida received a comprehensive report summarizing the results of the survey in this state, which they will wish to ponder.

In the summer of 1946, when the study was begun, there were 1,412 physicians in private practice in the state and 395 children per physician. There were 59 pediatricians in private practice and 9,472 children per pediatrician. Fifty-two of the pediatricians were located in cities of 10,000 or more population. The state as a whole had 17 per cent more children per physician than the average of eight selected comparable states. Children living in isolated rural counties received about 47 per cent of the amount of physicians' services received by children living in metropolitan counties.

Sixty-six per cent of physicians' visits to children were made by general practitioners. Even in metropolitan counties they saw almost twice as many children as did the pediatricians. On the average, they saw 20 patients in one day, but 6 per cent reported seeing 50 or more patients on the day assigned to them, and 43 per cent saw more than 20. Approximately 25 per cent of these patients were children, and less than one fourth of this number were well children. Reporting on a twenty-eight day period, pediatricians on an average day saw 18 patients. Other

specialists averaged 15 patients a day, 12 per cent of whom were children. These three types of practitioners saw about two thirds of the child patients in their offices.

Although general practitioners provided most of the medical services for children, 43 per cent of them reported that they had had none or less than one month's special training in pediatrics. Seminars to make added training in child health readily available to them are accordingly recommended in the report. Too, it is recommended that in localities where there are no pediatricians, a greater number of general practitioners devote more time to well children.

The Florida State Pediatric Association is to be commended for this able study, made with the invaluable cooperation of the Florida State Board of Health. Members of the Florida Medical Association will wish to lend assistance whenever possible in attaining the goals sought. In this report they will find constructive recommendations pertaining to the Florida Children's Commission, expansion of community health services, a rheumatic fever program, expansion of hospital facilities including better provision for the care of premature infants, and expansion of dental services, as well as suggestions for physicians' training in child health and services to children. Theirs is the key role in the long term program for abolishing existing inequities and deficiencies and making the progress that will win for Florida in the care of her children an enviable place among the states.

BRAIN VACATION

What happens when the brain blacks out? Scientists have long pondered what goes on in the human brain during periods of coma, anesthesia and blurring owing to mental illness. In June the results of four years' research by Dr. Seymour S. Kety and his associates of the University of Pennsylvania School of Medicine were announced. They worked on the theory that by measuring the flow of blood through the brain they might determine what happens during recesses of mental function. After a patient had inhaled a 15 per cent solution of nitrous oxide, they compared samples of gas-laden blood taken en route to and on leaving the brain.

These tests showed that the brain cells for the time being actually go on vacation, so to speak, in states of coma or anesthesia. Oxygen and glucose consumption drop to about half their normal rates, and metabolism of the brain is greatly decreased.

Studies by this method on patients with dementia praecox indicated that as much oxygen is required to maintain irrational thinking as rational thinking. In senile dementia, however, an actual decrease in the amount of oxygen being supplied to the brain was noted. This suggests an explanation for the slowing down of mental processes in aged persons.

This new technic indicates the state of the brain during surgical operations. It also promises aid in the search for the cause of high blood pressure, brain tumors and mental disease. It may even lead to new knowledge about cerebral arteriosclerosis, apoplexy, diabetes and uremia.

HOW FAR DO YOU WALK DAILY?

Do you ever wonder how far you walk in a day—especially on some days when hospital corridors seem longer than usual? A leaflet came our way recently giving the results of a pedometer survey made in several large cities. When the daily walking mileage of business men, housekeepers, salesmen, dancers, stenographers, children at play, waiters, conductors, policemen, letter carriers and salesgirls was recorded, it revealed some interesting averages.

In a single day the average distance walked was 18,098 steps, or 7⅞ miles. Exclusive of the walking he does away from business, the business man walks every three or four weeks a distance greater than from New York to Boston. A housekeeper, without leaving the house, walks annually a distance equal to that from Boston to San Francisco. At school and at play, a schoolgirl averages 11½ miles a day, a schoolboy 15 miles.

A physician in a hospital, who used his car when out of doors, walked 18 miles in a day. A golfer doing eighteen holes walked 8½ miles. A salesgirl walked 8 miles a day and a salesman 73 miles a week. Other totals were: a policeman, 14 miles in a day; a letter carrier, 22 miles a day; a department store buyer, 7 miles a day; a girl in a business office, 57 miles in a week; and a stenographer, who rode to and from work, 43 miles in a week.

How far do you estimate you walked yesterday? Last week? Last month? Your record for 1948 would probably surprise you.

MIDWINTER SEMINAR IN OPHTHALMOLOGY AND OTOLARYNGOLOGY

The annual University of Florida Midwinter Seminar in Ophthalmology and Otolaryngology will convene at Miami Beach on the tenth and continue through the fifteenth of this month. Headquarters for the Seminar will be at the Robert Richter Hotel on the Ocean, and the schedule is arranged to provide an ideal combination of work and pleasure at this famous winter resort. The registration fee is $40.

The lectures on Ophthalmology will be presented on January 10, 11 and 12, and those on Otolaryngology on January 13, 14 and 15. All who register for the Seminar are cordially invited to attend the Midwinter Convention of the Florida Society of Ophthalmology and Otolaryngology on Wednesday night, January 12. On that occasion Dr. John H. Dunnington of New York and Dr. A. C. Furstenberg of Ann Arbor will be the speakers, and there will be shown an extraordinary motion picture by Dr. H. G. Kobrak and Joseph E. Hind entitled "The Function of the Ear in Health and Disease."

The lecture periods will be from 9:00 to 10:00, 10:15 to 11:15 and 11:30 to 12:30 each morning, and 2:00 to 3:00 and 3:30 to 4:30 each afternoon. The lecturers and their subjects for each day follow in the order of presentation:

Monday, January 10: Pathology of Glaucoma, Georgiana Theobald, M.D., Chicago; Cycloplegic Refraction, Avery Prangen, M.D., Rochester; Surgical Treatment of Strabismus, John H. Dunnington, M.D., New York; Uveitis, Alan C. Woods, M.D., Baltimore; and Hypermature Cataract, Derrick Vail, M.D., Chicago.

Tuesday, January 11: Surgical Treatment of Glaucoma, John H. Dunnington, M.D., New York; Uveitis, Alan C. Woods, M.D., Baltimore; Optic Nerve Cupping, Derrick Vail, M.D., Chicago; Orbital Tumors, Georgiana Theobald, M.D., Chicago; and Contrast and Balance in Subjective Testing, Avery Prangen, M.D., Rochester.

Wednesday, January 12: Retinal Detachment, Derrick Vail, M.D., Chicago; Pathology of Sympathetic Ophthalmia, Georgiana Theobald, M.D., Chicago; Discussion of Some Unusual Problems in Refraction by Case Histories (Lantern Slide Demonstration), Avery Prangen, M.D., Rochester; Surgical Treatment of Detachment of the Retina, John H. Dunnington, M.D., New York; and Uveitis, Alan C. Woods, M.D., Baltimore.

Thursday, January 13: The Eustachian Tube: Tests for Tubal Function; Early Diagnosis and Management of Tubal Dysfunction; Chronic Secretory and Exudative Middle Ear Catarrh; Late Complications of Tubal Obstruction, John R. Lindsay, M.D., Chicago; Practical Considerations of Neurological Conditions Affecting the Nose, Throat and Larynx, A. C. Furstenberg, M.D., Ann Arbor; A General Lecture on the Histology, Histological Characteristics of the More Common Malignant Tumors, LeRoy Allen Schall, M.D., Boston; Physiology and Pathology of Bronchial Obstruction, Paul H. Holinger, M.D., Chicago; and Conservation of Hearing in the Chronic Ear, Philip E. Meltzer, M.D., Boston.

Friday, January 14: Malignant New Growths of the Nose and Nasal Accessory Sinuses, Including Symptomatology, Principles and Treatment and a Survey of Two Hundred and Nine Cases, LeRoy Allen Schall, M.D., Boston; Oral Pathology: What the Rhinologist Should Know Concerning It, Philip E. Meltzer, M.D., Boston; Kodachrome Clinic in Otolaryngology and Broncho-Esophagoscopy, Paul H. Holinger, M.D., Chicago; The Syndrome of Deafness, Tinnitus and Vertigo: Differential Diagnosis, Pathology and Treatment, John R. Lindsay, M.D., Chicago; and The Management of Acute and Chronic Nasal Accessory Sinus Diseases, A. C. Furstenberg, M.D., Ann Arbor.

Saturday, January 15: Bronchoscopy in Infants, Paul H. Holinger, M.D., Chicago; Recent Advances in Otolaryngology, A. C. Furstenberg, M.D., Ann Arbor; The Nasopharynx and the Eustachian Tube as Regards Radiation, X-Ray and Adenoidectomy, Philip E. Meltzer, M.D., Boston; New Growths Involving the Nasopharnyx, LeRoy Allen Schall, M.D., Boston; and Vertigo: Routine Examination; Significance of Postural Vertigo; Differential Diagnosis and Management, John R. Lindsay, M.D., Chicago.

SOUTHERN MEDICAL ASSOCIATION MIAMI MEETING

When the Forty-Second Annual Meeting of the Southern Medical Association ended in Miami the last week in October, the official attendance totaled 2,674. Of 1,595 physicians registered, 772 were from Florida, 508 from Dade County and 264 from elsewhere in the state.

The president of this organization is now Dr. Oscar B. Hunter of Washington, D. C., and the president-elect is Dr. Hamilton W. McKay of Charlotte, N. C. After several months' leave of absence, the secretary-manager, Mr. C. P. Loranz of Birmingham, resumed his duties on November 1.

The annual meeting this year is scheduled for November 14-17 with the Campbell-Kenton County Medical Society of Northern Kentucky as host. The principal cities of this two county society are Covington and Newport, immediately across the Ohio River from Cincinnati with its available hotels and other necessary physical facilities for this Kentucky meeting.

The registration list included the following members of the Florida Medical Association:

APALACHICOLA: Terry Bird. APOPKA: Thomas E. McBride. AVON PARK: Isaac W. Chandler. BALDWIN: William D. Brinson. BARTOW: Lamar L. Lancaster, Chester H. Murphy. BELLEVIEW: Edwin C. Hanson. BOYNTON BEACH: Nathaniel M. Weems, BRADENTON: Roderic O. Jones, Millard P. Quillian, William D. Sugg. CLEARWATER: William G. Mason. COCOA: Thomas C. Kenaston, Walter C. Page. COCONUT GROVE: Charles H. McDevitt, Jr. CORAL GABLES: A. Daniel Amerise, Gunnard J. Antell, Charles R. Burbacher, Henry H. Caffee, Philip J. Chastain, Edward H. Cowell, Robert F. Dickey, Otto S. Dowlen, Franklin J. Evans, Richard C. Forman, Dewey H. Grimes, Glenn H. Heller, Frank W. Hewlett, Charles F. Hudson, John A. Hughes, Robert P. Keiser, Edward L. Kinney, F. E. Kitchens, James F. Lyons, Lynn D. McCarley, Jr., William S. Piper, Warren W. Quillian, T. D.

Sandberg, William P. Smith, Herbert E. Sperry, Martiele Turner, Karl W. Vetter, William L. Wagener, Jr., Arthur H. Weiland, Hillard W. Willis.

CRESTVIEW: Rhett E. Enzor. DAYTONA BEACH: C. Robert DeArmas, George M. Green, Alphonsus M. McCarthy. DeLAND: William R. Hutchinson. DELRAY BEACH: James R. Nieder, Charles A. Robinson. FERNANDINA: Cecil B. Brewton, George A. Dame. FT. LAUDERDALE: Norris M. Beasley, Robert E. Blount, Mark Butler, Milton N. Camp, Russell B. Carson, Eugene C. Chamberlain, Anna A. Darrow, Frank Denniston, Burns A. Dobbins, Jr., Frederick J. Driscoll, Leroy B. Elliston, Roland F. Fisher, Donald H. Gahagen, Francis Haberman, Benjamin F. Hart, Elliott M. Hendricks, M. Austin Lovejoy, Richard A. Mills, Samuel P. Nixon, Henry J. Peavy, Francis D. Pierce, Thomas L. Roberts, Jr., Leign F. Robinson, Curtis H. Sory, Alva R. Taylor, S. Elliott Wilson. FT. MYERS: C. M. Askue, Joseph D. Brown, William H. Grace, H. Quillian Jones. FT. PIERCE: Haynsworth D. Clark, Francis A. Gowdy, Lester L. Whiddon.

GAINESVILLE: F. Emory Bell, J. Maxey Dell, Jr., Frank M. Hall, Albert G. Love, IV, James M. McClamroch, John E. Maines, Jr., DeWitt T. Smith, William C. Thomas. HIALEAH: Van. M. Browne, Alfred E. O'Neil, Leon H. O'Quinn. HOLLYWOOD: Dale T. Anstine, Arthur Brill, Robert R. Harriss, Garland M. Johnson, Robert J. Patterson. HOMESTEAD: Joseph M. Burton, Allen W. Logan. JACKSONVILLE: Robert M. Baker, Sullivan G. Bedell, Gerhard T. Beck, Edward Campelli, Lucien Y. Dyrenforth, A. Judson Graves, Albert V. Hardy, William G. Harris, Benj. F. Hodsdon, Luther W. Holloway, Gordon H. Ira, Thomas H. Lipscomb, John M. McDonald, Robert B. McIver, Charles B. Mabry, Paul H. Martin, A. Sherrod Morrow, Samuel R. Norris, G. Frederick Oetjen, Lorenzo L. Parks, Geo. W. Richardson, Shaler Richardson, Clarence M. Sharp, Lauren M. Sompayrac, Wilson T. Sowder, John T. Stage, H. Marshall Taylor, Daniel R. Usdin, Frederick J. Waas, Edward C. Watt, J. Frank Wilson. JACKSONVILLE BEACH: Adolph B. Cone. JUPITER: James C. Nowling.

KEY WEST: Leonard H. Conly, James B. Parramore. LAKE CITY: Thomas H. Bates, James F. Pitman. LAKELAND: Marion W. Hester, William P. Logan, James T. Shelden, Wylie L. Tillis. LAKE WORTH: A. Scott Turk. MARIANNA: Francis M. Watson, Courtland D. Whitaker. MELBOURNE: Theodore J. Kaminski. MIAMI: Lawrence Adler, Isadore H. Agos, Starling P. Alderson, Julius Alexander, Lasser Alexander, Ralph F. Allen, James L. Anderson, Edward R. Annis, Roger J. Arango, George C. Austin, Stanley H. Axelrod, Hubert A. Barge, William J. Barge, Ernest R. Barnett, Ralph E. Baxter, Martin S. Belle, Aaron Bernstein, Nelson M. Black, Jr., Morris H. Blau, William K. Boros, Carroll T. Bowen, John C. Branham, David Brezin, Andrew G. Brown, Earlsworth C. Brunner, John E. Burch, Reuben N. Burch, Henry Cadan, Orlon V. Carr, Jr., Bruce D. Carroll, Silas E. Chambers, Gail E. Chandler, Reuben B. Chrisman, Jr., Isaac B. Cippes, Marcus B. Cirlin, James W. Clower, Jr., George D. Conger, Milton M. Coplan, Vincent P. Corso, Edmonson S. Couric, Edward W. Cullipher, Benedict A. Cusani, David Davidson.

John E. Dees, Lydia A. DeVilbiss, Louise DeVore, John W. Dix, Percy L. Dodge, L. Washington Dowlen, Carl E. Dunaway, John G. DuPuis, Herbert Eichert, James O. Elam, Wm. H. Ellis, Raymond L. Evans, Frederick E. Farrer, Robert F. Farrington, George Ferre, James E. Fischer, Willard L. Fitzgerald. Emmett T. Fitzpatrick. Marvin G. Flannery, M. Eugene Flipse, M. Jay Flipse, Roger J. Forastiere, Forrest H. Foreman, Stanley Frehling, Bessie S. French, Elmo D. French, Tom. R. Gammage, Edmond Gamse, Herman Glassman, Francis W. Glenn. J. Raymond Graves, Fuad Hanna, James C. Hardman, Robert M. Harris. W. Tracy Haverfield, Ella M. Hediger, Charles C. Hillman, John R. Hilsenbeck, Andrew H. Hinton, Edward E. Hodsdon, Luther A. Hodsdon, William M. Howdon, R. Spencer Howell, Jack Humphreys, James J. Hutson, Thomas W. Hutson, William H. Izlar, Ralph W. Jack, Leslie M. Jenkins, S. Curtis Johnson, Walter C. Jones, Ferdinand H. Kauders, Jack J. Kaufman, Jr., Jack Keefe, 3rd, Paul Kelis, Ralph E. Kirsch, Morris E. Kuckku, Alexander Kushner, Carlos P. Lamar, William T. Lanier, George W. Lawson, Frederick LeDrew.

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BLUE SHIELD DOCTOR'S SERVICE REPORT

Proper completion of the Doctor's Service Report at the time a claim is made is of great importance to the physicians and to the Blue Shield Plan. Claims should be made on the Doctor's Service Report and sent to the Florida Medical Service Corporation not later than the last day of the month in which the patient is discharged. Prompt payment of claims depends on the completion in detail of these reports.

The proper name, contract number and group number of the Blue Shield member must be indicated so that no time will be lost in the identification of the patient. "Service Date" means the date of surgery, not the date that the contract became effective. Correct information as to the date that the physician advised the necessity of surgery protects not only the plan but also the physician since the plan can only continue to operate on its present rate and payment structure by paying legitimate claims. Claims for anticipated surgery are not honored.

Along this same line, the physician should indicate whether or not the patient was referred by another physician. If such is the case, it is necessary that the plan know the physician's name since he may have advised surgery before referring the patient, and the patient may have taken out a Blue Shield contract to cover the anticipated operation.

The next question concerns whether or not the patient was injured while working on the job. The rates charged by the plan are not set up to cover Workman's Compensation cases. It is necessary that the physician show on the report the place where surgery was performed. The contract covers minor surgery performed in the patient's home and the doctor's office as well as in the hospital, and major surgery performed in a hospital. The hospital where surgery is performed must be approved by the American Medical Association.

The final diagnosis, as well as the detailed surgical procedure, should be shown. The appearance of the identifying code number on the report will assist the plan in determining the payment to the physician. Special attention is called to the section of the report requesting the name of the radiologist, anesthetist, and/or pathologist on the case. Participating physicians who render these services and who are not in charge of the case will be reimbursed for such services. Supplemental reports will be sent to them.

The cooperation of participating physicians in promptly and properly completing the reports is an important factor in maintaining the reputation Blue Shield has already established for the prompt and fair payment of claims.

STATE BOARD OF HEALTH

Dr. Charles H. Blandford has been appointed director of the Marion County Health Department with headquarters at Ocala. Dr. Blandford was formerly the director of the Hardin County Health Department at Elizabethtown, Ky.

Dr. George A. Dame, director of the Bureau of Local Health Service of the Florida State Board of Health, was elected chairman of the Section on Public Health of the Southern Medical Association at its meeting in Miami, Oct. 25-28, 1948.

STATE NEWS ITEMS

Dr. J. Brown Farrior of Tampa received the First Award for his scientific exhibit entitled "The Fenestration Operation," which was shown at the annual meeting of the Southern Medical Association held in Miami in October.

Thirteen members of the Florida Medical Association attended the Clinical Congress of the American College of Surgeons which was held in Los Angeles in October. They are Drs. Gordon H. McSwain, Arcadia; Joe I. Turberville, Century; F. Hardy Bowen, Jacksonville; Edgar Watson, Lakeland; Howard G. Holland, Leesburg; John W. Snyder, Miami; Thomas C. Butt, Carl D. Hoffmann, Eugene L. Jewett, Carl S. McLemore, Wm. E. Westcott, Orlando; Luther C. Fisher, Jr., Pensacola; J. Brown Farrior, Tampa.

The next written examination and review of case histories (Part I) for all candidates to the American Board of Obstetrics and Gynecology will be held in various cities of the United States and Canada on Feb. 4, 1949. Notice of the exact time and place of the examinations will be sent to all candidates in advance of the examination date. Candidates who successfully complete the Part I examination proceed automatically to the Part II examination to be held May 8-14, 1949 at the Hotel Shoreland in Chicago.

Application forms and bulletins are sent upon request made to American Board of Obstetrics and Gynecology, 1015 Highland Building, Pittsburgh 6.

The second midwinter meeting of the Florida Society of Ophthalmology and Otolaryngology will be held at the Robert Richter Hotel in Miami Beach on Wednesday, January 12. The scientific program will be opened at 8 p.m. by Dr. Bascom H. Palmer, president of the society. A motion picture entitled, "The Function of the Ear in Health and Disease," by Dr. H. G. Kobrak and Joseph E. Hind, will be shown by Dr. Paul H. Holinger of Chicago. Dr. John H. Dunnington of New York will speak on "Thoughts on Some Surgical Subjects." Dr. A. C. Furstenberg of Ann Arbor, Mich., will speak on "A Clinical Consideration of Tumors and Cysts of Teratological Origin."

Dr. Leland F. Carlton of Tampa was elected president of the Association of Seaboard Air Line Railway Surgeons at the annual convention held in St. Petersburg in November. Dr. Francis H. Langley, president of the Pinellas County Medical Society, made an address of welcome.

Dr. V. Marklin Johnson of West Palm Beach was elected to serve a three-year term on the Board of Censors of the American Society of Clinical Pathologists at the annual meeting which was held in Chicago in October.

The Miami Obstetrical and Gynecological Society will hold its next regular meeting on January 13 at the El Comodoro Hotel in Miami. The newly-elected officers for the 1948-49 term are Drs. Homer L. Pearson, president; Ralph W. Jack, vice president; John D. Milton, secretary; Edward F. Fox, treasurer; Robert T. Spicer, member of the council; Harry Kraff, editor of Transactions.

The United States Chapter of the International College of Surgeons will hold a sectional meeting in Miami on January 20 and 21.

MARRIAGES AND DEATHS

MARRIAGES

Dr. Abraham J. Gorday of St. Petersburg and Miss Carmel Dunford were married on Aug. 22, 1948.

DEATHS—MEMBERS

Dr. Leonard A. Baker, Miami	Nov. 5, 1948
Dr. William H. Bradford, Chevy Chase, Md.	Nov. 15, 1948
Dr. Arthur W. Wood, Miami	Nov. 21, 1948
Dr. Bruce F. Butler, Hollywood	Nov. 12, 1948

DEATHS—OTHER DOCTORS

Dr. Paul Beachamp, Science Hill, Ky.	June, 1948
Dr. George W. Wood, Oxford	Nov. 2, 1948
Dr. James M. Lilly, Fayetteville, N.C.	Aug. 1, 1948
Dr. George W. Sherouse, Campville	Nov. 29, 1948

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Editor's Note:

The purpose of the Academy is to promote a program of public relations under the supervision of the Florida Medical Association. At present all officers and members of the Academy are also members of the Florida Medical Association.

Legislation of vital concern to the medical profession will hold the spotlight in the days immediately ahead. Many are figuring that this is the crucial year. Some form of compulsory health insurance legislation is certain to receive consideration by the Eighty-First Congress. The Washington office of the American Medical Association advises that it will be wise to await the President's message to Congress before attempting to predict the probable course of events. In the meantime, doctors who are acquainted with Congressmen can see that these gentlemen are informed as to the dangers inherent in tampering with the present system of medical care in this country.

Dr. Rufus Thames of Milton was the choice of the Florida Medical Association to represent this state in the national "General Practitioner of the Year" contest, sponsored annually by A.M.A. Information concerning Dr. Thames and his contribution to the medical profession can be found in the December issue of The Journal.

Tribute to these outstanding men of medicine by their fellow physicians offers the best in medical public relations. All throughout the state, as his story was read in newspapers or heard on the air, people heard the name of a West Florida physician but they saw the face of their own family doctor. For some time to come, at least, it will be difficult to sell these people on a different kind of medical system, for this country.

The Leon-Gadsden-Liberty-Jefferson-Wakulla County Medical Society devoted its regular quarterly meeting on November 4 to a program designed to acquaint the members of the society with the legislative and public relations programs of the State Association. Dr. J. Maxey Dell, Jr., and Mr. Ernest R. Gibson of the Academy were present to explain these programs on the state level and to make suggestions as to the aid which must come from the component societies.

On November 20 the initial issue of the official newsletter of the Florida Medical Association made its appearance. Known as BRIEFS these bits of pertinent information are ably described by the title. It is hoped that these briefs, timely, short and to the point, are proving of value to the members.

Currently these are being mailed to the presidents, secretaries and chairmen of legislative and public relations committees of county medical societies, officers and chairmen of committees of the State Association and others. A copy will be mailed directly to any member of the Association upon request.

"Health Topics," an educational column prepared exclusively for weekly and semi-weekly newspapers, is now being translated into Spanish.

Shortly after the introduction of "Health Topics," editor Ruben Fabelo of the YBOR CITY SUNDAY NEWS requested a mat of the heading. Said Mr. Fabelo, "We can change the English words and use the emblem." Now these columns are appearing regularly in this newspaper in Spanish. The same caduceus as appears in English newspapers is there, but the words beside it are "Topicos de Salud."

Federal Security Administrator Oscar Ewing well recognizes the potency of an educational campaign carried on at the local level. He has urged state and territorial health officers to carry his illogical arguments favoring a national health insurance to the "grass roots."

No group has better facilities than the medical profession with its county medical societies to utilize the procedure of local approach. There is an excellent opportunity for each medical society to

beat Mr. Ewing at his own game by taking steps to see that its own public is well informed as to the dangers inherent in tampering with a system of medical care second to none in the world.

NEW MEMBERS

The following doctors have joined the State Association through their respective county medical societies during the month.

Barney, Burton F., West Palm Beach
Engle, Howard A., Miami Beach
Glenn, Walter J., Jr., Ft. Lauderdale
Hockenberry, Everette D., Miami
Jenkins, Paul H., Orlando
Norman, Estella G., Miami Springs
Ragland, Robert B., Jacksonville
Schwarz, Charles A., Miami Beach
Stein, Charles, Miami
Zuckerman, Leo A., Miami Beach

COMPONENT SOCIETY NOTES

DeSOTO-HARDEE-HIGHLANDS-CHARLOTTE-GLADES

The November meeting of the DeSoto-Hardee-Highlands-Charlotte-Glades County Medical Society was held at the Aqua Vitae Springs. The guest speaker, Dr. J. Brown Farrior of Tampa, presented papers on "Treatment of Cancer of the Larynx" and "The Fenstration Operation for Deafness." The papers were illustrated with slides and movies.

LEON-GADSDEN-LIBERTY-WAKULLA-JEFFERSON

The quarterly meeting of the Leon-Gadsden-Liberty-Wakulla-Jefferson County Medical Society was held in Quincy on November 4. At the business meeting the following officers were elected for 1949: Dr. Merritt R. Clements of Tallahassee, president; Dr. James B. O'Connor of Chattahoochee, vice president; Dr. Edward C. Love, Jr., of Quincy, secretary-treasurer.

A program was devoted to a consideration of medical public relations and was highlighted with talks by Dr. J. Maxey Dell, Jr., of Gainesville and Mr. Ernest R. Gibson of Jacksonville, executive secretary of the Florida Academy of Public Medicine.

MARION

The annual seafood suppor of the Marion County Medical Society was held on November 17 at the Magnolia Lodge in place of the regular monthly meeting. Refreshments were served to the following doctors and their wives: Drs. William H. Anderson, Jr., Hugh H. Barfield, T. Hartley Davis, Bertrand F. Drake, William H. Garvin, Jr., Henry L. Harrell, Carl S. Lytle, William J. McGovern, John N. Moore, Eugene G. Peek, Eugene G. Peek, Jr., Ralph E. Russell, E. Laurence Scott, Robert E. Thompson and Herbert M. Webb, Jr. Dr. William B. Moon of Crystal River was a guest.

NASSAU

Members of the Nassau County Medical Society met on November 26 and elected officers for the 1949 term. Dr. David G. Humphreys was chosen president of the society and Dr. John W. McClane was re-elected secretary-treasurer.

PASCO-HERNANDO-CITRUS

Members of the Pasco-Hernando-Citrus County Medical Society were entertained at the November meeting by Dr. S. Carnes Harvard of Brooksville. At the meeting, Dr. William G. Mason reported on the blood bank meeting which had been held in Pinellas County and Dr. Robert G. Nelson of Tampa, a guest, discussed the recent cancer seminar held in Tampa.

The following members attended the meeting: Drs. William H. Walters, Jr., John T. Bradshaw, George R. Creekmore, S. Carnes Harvard, William G. Mason, William B. Moon. Guests included Drs. William H. Garvin, Jr., of Dunnellon, Arthur R. Knauf, Blackburn W. Lowry and Robert G. Nelson, all of Tampa.

PINELLAS

At the November 1 meeting of the Pinellas County Medical Society, a motion was passed to form a Cancer Control Clinic. Action was taken following a talk on the cancer control program by Dr. Roger F. Sondag, director of the Bureau of Preventable Diseases of the Florida State Board of Health.

Resolutions approving the adoption and enforcement of the Rabies Control Ordinance were adopted. Resolutions approving mass chest x-ray studies by the Florida State Board of Health also were adopted.

Dr. Albert R. Frederick, chairman of the scientific program and entertainment committee, introduced Dr. Walter H. Winchester who spoke on tetanus and presented a case report. The

report was discussed by Drs. T. Paul Haney, director of the Pinellas County Health Unit, Edward L. Cole, Jr., Rowland E. Wood, M. Eldridge Black and Roderick C. Webb.

POLK

Members of the Polk County Medical Society held their first fall meeting on October 25. The speakers included Drs. Duncan T. McEwan and Robert E. Zellner of Orlando, who spoke on "Substernal Goiter." Dr. Roger F. Sondag, director of the Bureau of Preventable Diseases of the Florida State Board of Health, spoke on the need of cancer clinics.

PUTNAM

At the November meeting of the Putnam County Medical Society, Dr. Eugene H. Silverstone of the Veterans Administration, Lake City, spoke on low back strain and intervertebral disk. Dr. Lawrence G. Hebel presented a reel on angina pectoris, illustrating the symptoms and treatment.

Members present included Drs. Grover C. Collins, James W. Davidson, Edward W. Ford and Bernard E. Kane.

ST. LUCIE-OKEECHOBEE-MARTIN

At a regular meeting of the St. Lucie-Okeechobee-Martin County Medical Society held on November 18 at Stuart, the following officers were elected to serve during 1949: Dr. Adrian M. Sample, president; Dr. Steve R. Johnston, vice president; Dr. Jerome A. Megna, secretary-treasurer.

SARASOTA

Members of the Sarasota County Medical Society met on November 9 at the Sarasota Bay Country Club to hear Dr. F. Bayard Carter, professor of obstetrics and gynecology at Duke University, Durham, N. C., and Dr. Walter L. Thomas, associate professor.

SEMINOLE

Members of the Seminole County Medical Society held a supper meeting at the Anchor in October with Dr. Harry Z. Silsby presiding. Members present included Drs. Orville L. Barks, Wade H. Garner, Leonard I. Munson, Charles L. Parks, Frank L. Quillman, James A. Smith and Julian N. Tolar. Dr. Charles M. Callis of Sanford was a guest

EDWARD MEADOW

Dr. Edward Meadow of Miami died of a heart attack on Oct. 10, 1948 at the Biscayne Hospital in that city. He was 39 years of age.

Dr. Meadow was born in Omaha, Neb., and received his medical training at the Loyola University School of Medicine in Chicago, from which he was graduated in 1935. He came to Miami from Canton, Ohio, ten years ago. His skill in surgery received nationwide attention in 1947 when he performed a successful operation on a patient who had suffered an internal hemorrhage.

He was the first director of the Biscayne Hospital when it was founded in 1946. At the time of his death, he was one of the owners as well as president and chief of the surgical staff of the hospital.

Dr. Meadow was a fellow of the American Medical Association and a member of the Florida Medical Association and the Dade County Medical Association. Locally, he was a member of the Harvey Seeds Post of the American Legion.

He is survived by his wife, Mrs. Sarah Meadow; his mother, Mrs. Jennie King; two sisters, Mrs. Ruth Ricco and Miss Elizabeth Meadow, all of Miami; and his father, Meyer Meadow of Canton, Ohio.

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*Collins, E. N.: The Diagnosis and Treatment of Irritable Colon: Physiologic, Local, Irritative and Psychosomatic Factors, M. Clin. North America 32:398 (March) 1948.

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SARASOTA AUXILIARY ENTERTAINS

Wives of the physicians who attended the Southwest Medical District Meeting of the Florida Medical Association on Wednesday, October 20, were entertained by the Woman's Auxiliary to the Sarasota County Medical Society assisted by wives of Manatee county physicians.

A tour through the Ringling Home was followed by an informal afternoon tea on the grounds of the Villa Serena. Later in the evening the wives joined the doctors for dinner at the Sarasota Bay Country Club.

Mrs. Lee E. Parmley of Winter Haven, president of the Woman's Auxiliary to the Florida Medical Association, Mrs. Chester H. Murphy of Bartow, past president, and Mrs. Robert J. Jahn of Winter Haven, chairman of the state committee on organizaton, were among the guests.

HYGEIA

Since 1931 the national auxiliary has accepted as one of its projects the promotion of the distribution of Hygeia. In addition to being a source of authentic health information, this publication is especially adapted to the laymen.

Members of the auxiliary should endeavor to:

1. Make every member of the Florida Medical Association a subscriber.
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Discussing the general treatment of low back pain in a recent article, an orthopedic surgeon* comments on supports (among other items) as follows: "The second remedy tried by time is further rest provided by support after the patient gets out of bed. Various corsets, braces, and casts have been used and the one criterion is that they be well fitted and do the work intended."



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**Hugh T. Jones, M.D.*
Low Back Pain from the Orthopedic Standpoint
California Medicine
Vol. 68, February, 1948

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BOOKS RECEIVED

YOUR BABY, THE COMPLETE BABY BOOK FOR MOTHERS AND FATHERS. By Gladys Denny Shultz and Lee Forrest Hill, M.D. Price, $3.50. Pp. 278. New York: Doubleday & Co., Inc., 1948.

This unique and particularly attractive book by Gladys Denny Shultz, contributing editor of the Ladies' Home Journal, and Dr. Lee Forrest Hill, former president of the American Academy of Pediatrics, is the first book to recognize that Father as well as Mother needs instruction. It contains all the information a new father ought to know and explains how a father, by sharing in the care of the child, can get to know and understand his frequently bewildering offspring.

The book is filled with pertinent information for expectant mothers, and contains chapters of vital information incorporating latest changes in medical thinking. A special feature is the picture section, in which important instructions are illustrated by photographs and drawings. There is also a record section which, when filled in, will make the book a treasured personal history of the baby's early years. Covering everything from the time pregnancy is first suspected, through birth, infancy, and up to the time the child reaches school age, the book is thoroughly readable, complete and easy to understand.

CANCER MANUAL, STANDARDS FOR THE DIAGNOSIS AND TREATMENT OF CANCER. By the Cancer Committee of the Iowa State Medical Society. Ed. 2. Price $1.00. Pp. 160. Iowa City, Iowa: Athens Press, 1948.

This Cancer Manual is a compendium for the medical profession. The first edition in 1937 proved so popular that well over 50,000 copies were distributed to the physicians of several states. The present edition embodies the many developments of the intervening eleven years in the fields of cancer diagnosis and therapy.

The volume is offered as a fresh reminder that cancer, the second leading cause of death, kills 3,600 people annually in Iowa, one every three hours, and that probably one half of these deaths could be prevented by earlier treatment. It discusses cancer in the various parts of the body under such headings as early and late signs, history, diagnosis, differential diagnosis, treatment and prognosis.

CONTROL OF PAIN WITH SADDLE BLOCK AND HIGHER SPINAL ANESTHESIA. Edited by J. H. Walton, M.D. Pp. 52. Summit, N. J.: Ciba Pharmaceutical Products, Inc., 1948.

This booklet describes and illustrates the use of saddle block for obstetric analgesia and for surgical procedures, and spinal anesthesia for abdominal section, devoting a final section to nupercaine, its chemistry and pharmacology.

A BRIEF HISTORY OF THE SOUTH CAROLINA MEDICAL ASSOCIATION. By Joseph Ioor Waring, M.D. Pp. 197. Charleston, S. C.: The South Carolina Medical Association, 1948.

As a feature of the 1948 Centennial Meeting of the South Carolina Medical Association, a committee headed by Dr. J. I. Waring prepared "a sketch of medicine in the state in respect to its organized form, that is to say, a brief story of those agreements and disagreements between physicians themselves, between physicians and the public, or its legislators, those efforts for improvement of training and efficiency of doctors of medicine, as well as those attempts to better the private lot of the doctor himself." As it traces the beginnings and the growth of organized efforts of physicians to improve the status of themselves, their patients and the public health of the state, the account takes stock of the vagaries of the association's youth and the more stable philosophy which it has acquired in its century of life. This valuable contribution to medical history includes, in addition, short historical sketches of various medical societies and institutions of South Carolina.

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Surgical Pathology every Two Weeks.
GYNECOLOGY—Intensive Course, Two Weeks, starting February 21, March 21.
Vaginal Approach to Pelvic Surgery, One Week, starting February 14.
OBSTETRICS—Intensive Course, Two Weeks, starting March 7.
MEDICINE—Intensive Course, Two Weeks, starting April 4.
Personal Course in Gastroscopy, Two Weeks, starting March 7.
PEDIATRICS—Intensive Course, Four Weeks, starting April 4.
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ORGANIZATION	PRESIDENT	SECRETARY	ANNUAL MEETING
Florida Medical Association	Joseph S. Stewart, Miami	Robert B. McIver, Jacksonville	Belleair, Apr. 10-13, 1949
Florida Medical Districts	Herman Watson, Lakeland	Council Chairman	
A-Northwest	Irby H. Black, Live Oak	William P. Hixon, Pensacola	Quincy, 1949
B-Northeast	Rabun H. Williams, Eustis	Charles C. Grace, St. Augustine	Palatka, 1949
C-Southwest	John M. Butcher, Sarasota	H. Quillian Jones, Ft. Myers	Sebring, 1949
D-Southeast	Russell B. Carson, Ft. Lauderdale	Erasmus B. Hardee, Vero Beach	Ft. Lauderdale, 1949
Florida Specialty Societies			
Derm. and Syph., Soc. of	A. Buist Litterer, Miami	Wesley W. Wilson, Tampa	Belleair, April 10, 1949
Genl. Practice of Med.	M. Crego Smith, Clearwater	Walter E. Murphree, Gainesville	Belleair, April 10, 1949
Health Officers' Society	Roger F. Sondag, Jacksonville	Lorenzo L. Parks, Jacksonville	Belleair, April 10, 1949
Industrial & Railway Surgeons	F. Hardy Bowen, Jacksonville	J. H. Mitchell, Jacksonville	Belleair, April 10, 1949
Neurology & Psychiatry	James G. Lyerly, Jacksonville	William H. McCullagh, Jacksonvill	Belleair, April 10, 1949
Ob. and Gynec. Society	Chas. J. Collins, Orlando	Dorothy D. Brame, Orlando	Belleair, April 10, 1949
Ophthal. & Otol., Soc. of	Bascom H. Palmer, Miami	W. Jerome Knauer, Jacksonville	Belleair, April 10, 1949
Orthopedic Society	Charles B. Mabry, Jacksonville	Eugene L. Jewett, Orlando	Belleair, April 10, 1949
Pathological Society	James N. Patterson, Tampa	Gretchen V. Squires, Pensacola	Belleair, April 10, 1949
Pediatric Association, State	Edgar W. Stephens, W. P. Beach	Hugh A. Carithers, Jacksonville	Belleair, April 10, 1949
Proctologic Society	Dean W. Hart, St. Petersburg	Frederick E. Farrer, Miami	Belleair, April 10, 1949
Radiological Society	James F. Pitman, Lake City	Floyd K. Hurt, Jacksonville	Belleair, April 9-10, 1949
Urological Society	Milton M. Coplan, Miami	Russell B. Carson, Ft. Lauderdale	Belleair, April 10, 1949
Florida—			
Academy, Public Medicine	Robert T. Spicer, Miami	Shaler Richardson, Jacksonville	Belleair, April 13, 1949
Basic Science Exam. Board	Paul A. Vestal, Winter Park	M. W. Emmel, D.V.M., Gainesville	Gainesville, June 11, '49
Dental Society, State	Horace L. Cartee, D.D.S., Miami	John I. Todd, D.D.S., Jacksonville	
Hospital Association	Mr. H. Louie Wilson, Gainesville	Mr. H. A. Schroder, Jacksonville	November, 1949
Hospital Service Corporation	Mr. W. E. Arnold, Jacksonville	Mr. H. A. Schroder, Jacksonville	Jacksonville, Feb., 1949
Medical Examining Board	Homer L. Pearson, Jr., Miami	Frank D. Gray, Orlando	
Medical Postgraduate Course	Turner Z. Cason, Jacksonville	Chairman	
Medical Service Corporation	Leigh F. Robinson, Ft. Lauderdale	Herbert E. White, St. Augustine	Belleair, April, 1949
Nurses Association, State	Mrs. Elsie M. Airheart, Tampa	Miss Helen Shearston, Miami	Sarasota, October, '49
Pharmaceutical Association, State	Mr. D. M. Weaver, Miami	Mr. R. Q. Richards, Ft. Myers	Miami, May 17-19, '49
Public Health Association	Turner E. Cato, Miami	Mr. Fred B. Ragland, Jacksonville	West Palm Beach, Oct. 6-8, '49
Tuberculosis & Health Assn.	Judge Ernest E. Mason, Pensacola	Mr. Walton MacJordan, Orlando	May, 1949
Woman's Auxiliary	Mrs. L. E. Parmley, Winter Haven	Mrs. C. R. Morgan, Jr., Miami	Belleair, Apr. 10-13, 1949
American Medical Association	R. L. Sensenich, South Bend, Ind.	Geo. F. Lull, Chicago	Atlantic City, June 6-10, 1949
Southern Medical Association	E. L. Henderson, Louisville, Ky.	C. P. Loranz, Birmingham	Cincinnati, Nov. 14-17, '49
Alabama Medical Association	J. Paul Jones, Camden, Ala.	Douglas L. Cannon, Montgomery	Montgomery, Ala., Apr. 19-21, 1949
Georgia, Medical Assn. of	Edgar Hill Greene, Atlanta	Edgar D. Shanks, Atlanta	Savannah, Ga., May 10-13, '49
S. E. Hospital Conference	Mr. Burton M. Battle, New Orleans	Mr. R. F. Whitaker, Atlanta	Biloxi, Miss., April 27-29, '49
Southeastern Allergy Assn.	Clarence L. Laws, Atlanta	Kath. B. MacInnis, Columbia, S. C	Durham, N. C., Jan. 22-23, '49
Southeastern, Am. College Phys.	Webster Merritt, Jacksonville	Florida Program Chairman	
Southeastern, Am. Urological Assn.	Harold P. McDonald, Atlanta	Russell B. Carson, Ft. Lauderdale	Boca Raton, March 21-24, '49
Southeastern Surgical Congress	Gilbert Douglas, Birmingham, Ala.	B. T. Beasley, Atlanta	Biloxi, Miss., Jan. 24-27, '49

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The Journal
OF THE FLORIDA MEDICAL ASSOCIATION

Vol. XXXV FEBRUARY, 1949 No. 8

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Elwyn Evans

Saddle Block Analgesia for Obstetrics
Thomas H. Bates

Safeguards in Antibiotic Therapy
Joseph Farrington and J. Frank Wilson

Will Our Leaders Give Us a Constructive Program Adequate to Fight Compulsory Health Insurance?
An Editorial

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Volume XXXV FEBRUARY, 1949 No. 8

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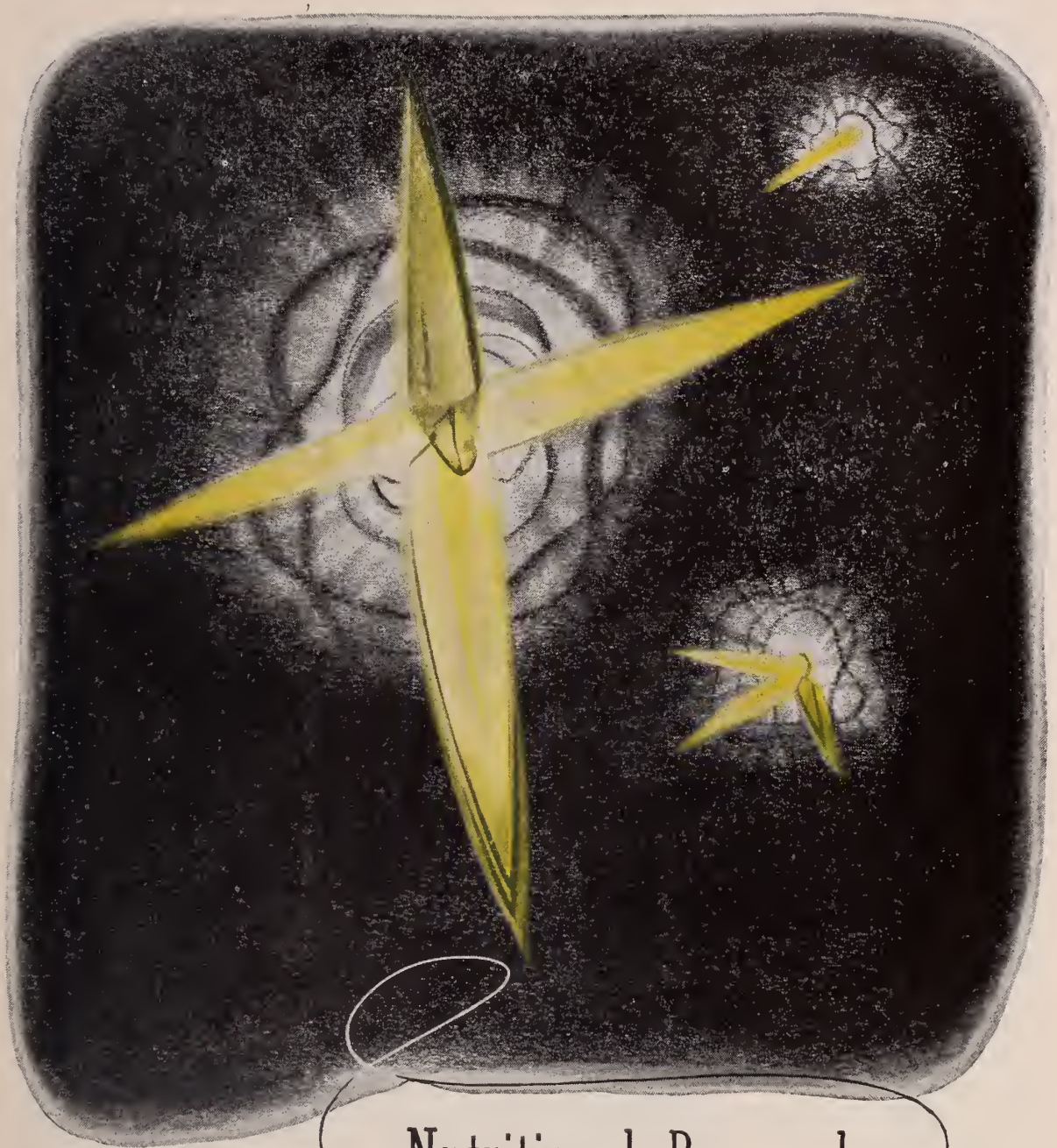
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This Journal is not responsible for the opinions and statements of its contributors.

Published monthly at Jacksonville, Florida. Price $5.00 a year; single numbers, 50 cents. Address Journal of the Florida Medical Association, P. O. Box 1018 (Fla. Theater Bldg.), Jacksonville 1, Fla. Telephone 6-1571. Accepted for mailing at special rate of postage provided for in Section 1103, Act of Congress of October 3, 1917; authorized October 16, 1918. Entered as second-class matter under Act of Congress of March 3, 1879, at the post office at Jacksonville, Florida. October 23, 1924.



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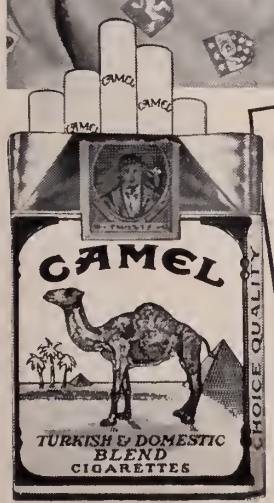
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[1] Boss, E.P.: The Physiologic and Clinical Phenomena of Aging, New Orleans M. & S. J. *97*:64 (Aug.) 1944.

[2] Spies, T.D., and Collins. H.S.: Observation on Aging in Nutritionally Deficient Persons, J. Gerontol. *1*:33 (Jan.) 1946.

[3] Stieglitz, E.J.: Therapy of the Aged, M. Ann. District of Columbia *17*:197 (Apr.) 1948.

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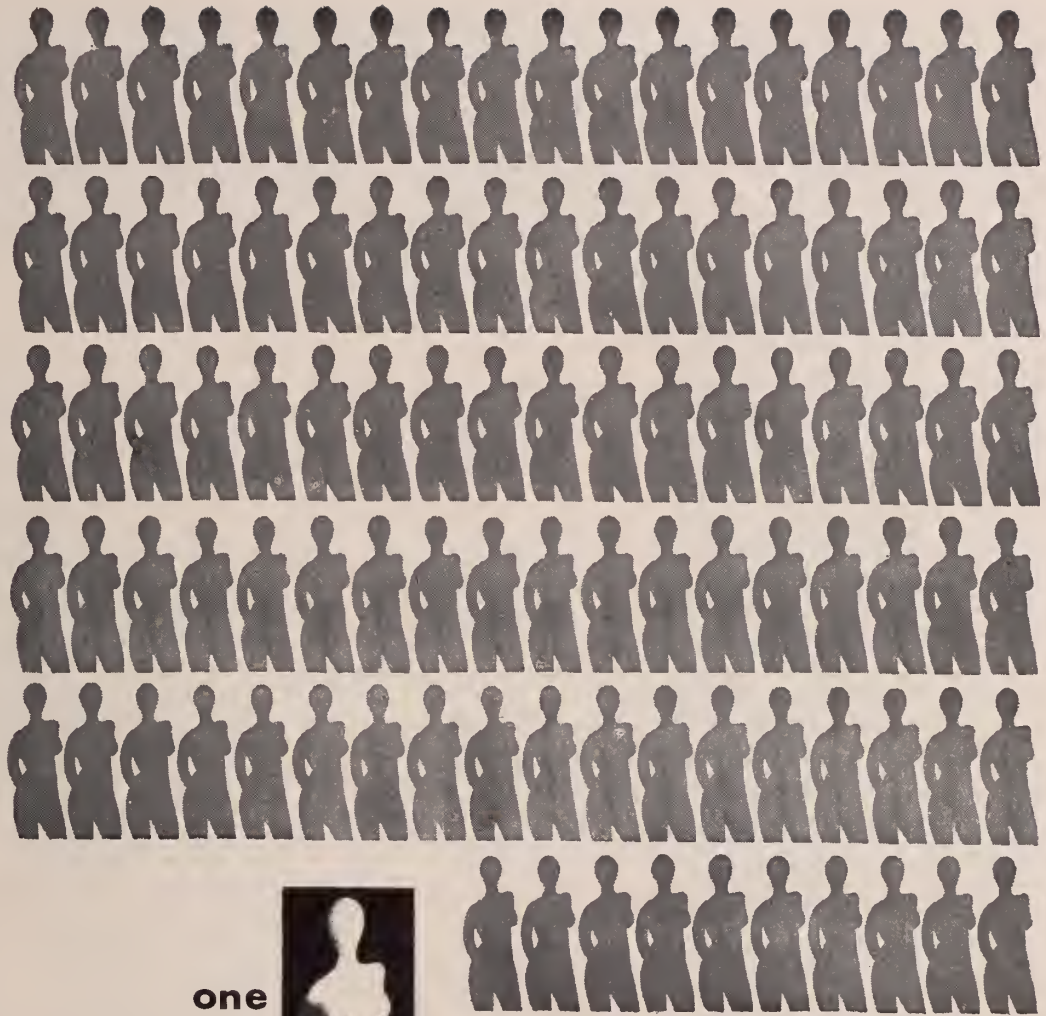


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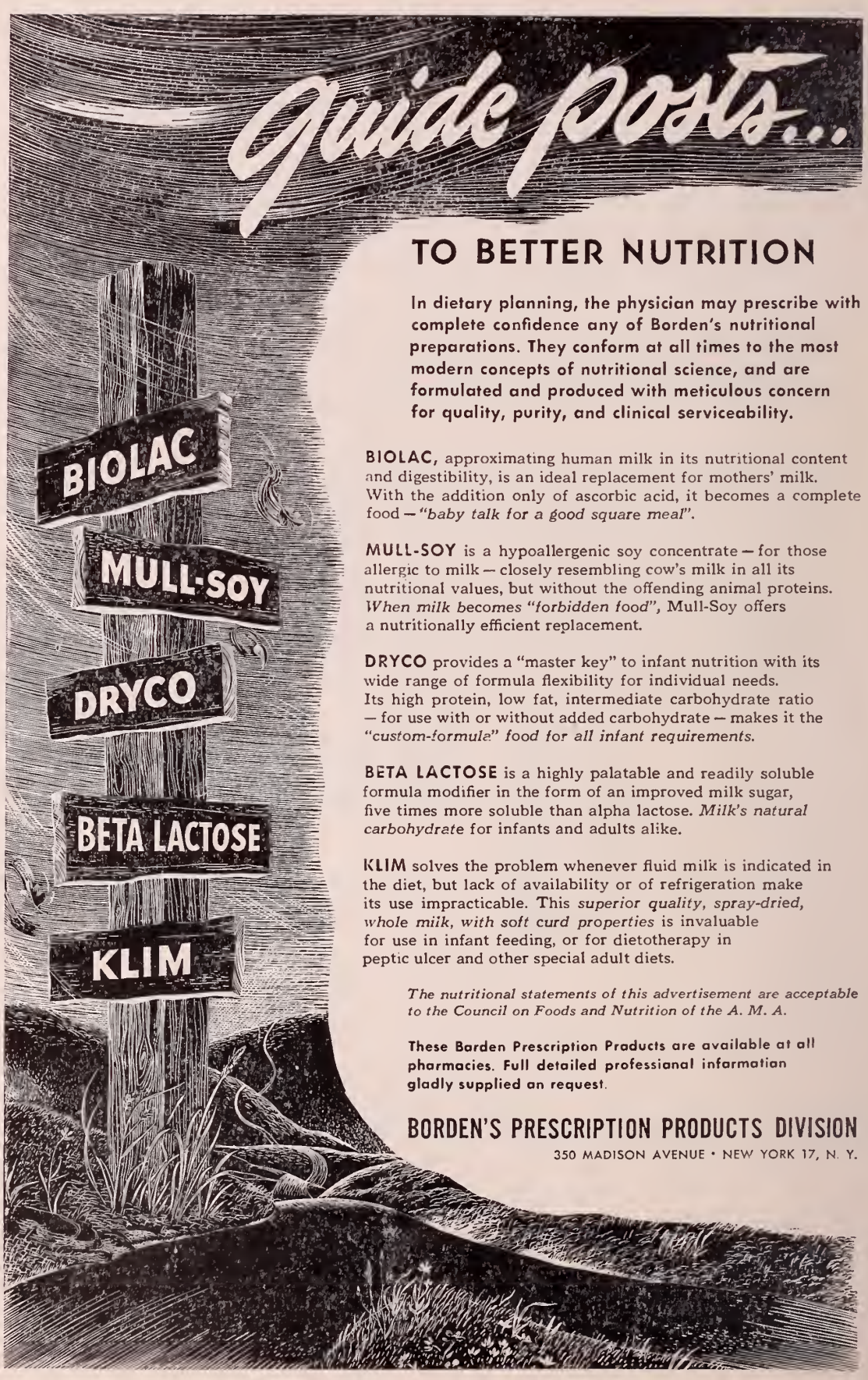
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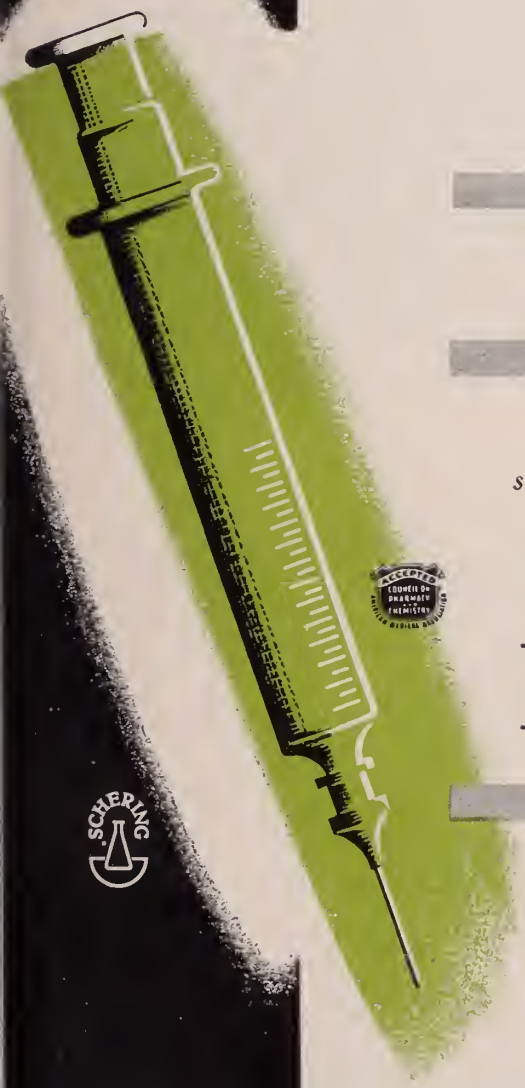
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BIBLIOGRAPHY: 1. Simon S.: J.A.M.A. 138:127, 1948. 2. Pearman, R. O.: New England J. Med. 228:507, 1943. 3. Kearns, W. M., Hefke, H., and Morton, S. A.: J. Urol. 56:392, 1946

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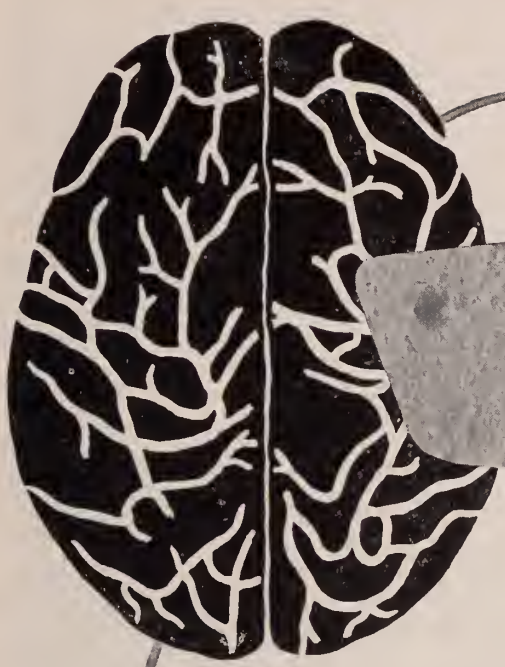
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*Snyder, M. L., Kiehn, C. L. and Christopherson, J. W.: Mil. Surgeon, *97*: 380, 1945. • Shipley, E. R. and Dodd, M. C.: Surg., Gynec. & Obst., *84*: 366, 1947 • Mays, J. L.: J. Med. Assoc. Georgia, *36*: 263, 1947. • Curtis, L.: Surg. Clin. N. America, 1466 (Dec.) 1947.



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THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION
PUBLISHED MONTHLY
Volume XXXV Jacksonville, Florida, February, 1949 No. 8

Congenital Heart Disease

ELWYN EVANS, M.D.
ORLANDO

Congenital defects of the heart and great vessels comprise 1 to 5 per cent (average 2 per cent) of the total incidence of heart disease after infancy. The relative incidence in children varies in different parts of the world, depending mainly on the incidence of rheumatic fever, being high in the tropics and relatively low in New England, where it is about 6 per cent.[1]

The etiology is generally unknown. In Abbott's series of 1,000 cases[2] there was a definite heredity factor in 1 per cent. In about 2 per cent there were congenial anomalies elsewhere in the body. I have seen a family in which the father and only son and daughter had coarctation of the aorta. Infections, such as German measles in the mother during the first two months of pregnancy, are apparently responsible in some cases.[3]

Specific diagnosis beyond stating that a congenital anomaly existed was not often made before Abbott's atlas was published in 1936,[2] and if a specific diagnosis was made, nothing could be done about it. But the picture has been changed.

The remainder of this discussion will deal predominantly with defects or combinations of defects amenable to surgery. These include patent ductus arteriosus, coarctation of the aorta, pulmonary stenosis or atresia most often seen in tetralogy of Fallot and defects of the aortic arch which produce vascular rings compressing the trachea and esophagus. Generally, specific diagnosis can be made clinically, and a definite decision can be reached as to whether or not the patient is a candidate for surgery. Occasionally, however, catheter studies are necessary.

Patent ductus arteriosus is the third most common defect, auricular and ventricular septal defects being more common. Before birth, the ductus arteriosus shunts blood around the unexpanded lungs. After birth, it should not persist over three months.[1] It occurs more often as a complicating than as a primary defect and is often compensatory. In infants and, rarely, young children the murmur may be slight or absent or only systolic in time. Characteristically it is a continuous murmur with systolic accentuation, often described as a machinery murmur, best heard in the first or second left interspace. This murmur, plus a prominence in the region of or just above the pulmonary artery, observed on roentgen examination, is pathognomonic. The heart may or may not be enlarged, depending on the amount of shunt. The electrocardiogram is helpful mainly in a negative way. Occasionally there is left axis deviation, rarely right axis deviation, and when the latter occurs a complicating defect should be suspected.

Graybiel, Strieder and Boyer[4] attempted the first operation on the patent ductus arteriosus in 1938. They, unfortunately, chose a difficult case with superimposed subacute bacterial endarteritis and so much local inflammation that the operation could not be completed. Incidentally, the operation has been performed many times since then on patients with superimposed bacterial endarteritis, the infection being cured with and without chemotherapy.[5,6a]

Gross and Hubbard[6b] reported the first successful attempt at obliterating the ductus in 1939. Gross[6a,c] now has a series of over 200 cases with an operative mortality of only a little over 3 per cent. Excellent results were obtained in all but 20 per cent of the 43 cases in which ligation of the ductus was employed. In about 10 per cent the ligature partially cut through, and some fistula was re-established. In the remaining 10 per cent, the ligature was not tied tightly enough to close off all the shunt. Gross now prefers division of the ductus. In the latter group, the mortality rate has been only 2.6 per cent.

Coarctation of the aorta is not a rare defect if it is looked for, and there are all degrees of constriction. There are two general types: (1) the infantile, and (2) the adult. The former consists of a narrowing of the whole isthmus, that portion of the aorta between the left subclavian artery and the ductus arteriosus. The proximal arch itself is sometimes involved. This is a fetal condition which may persist for a few weeks

Read before the Florida State Pediatric Association, Orlando, Oct. 26, 1947.

after birth, but is not compatible with long life. It is usually associated with other important anomalies. In fetal life, blood passes through the ductus arteriosus; so the proximal portion of the aorta remains hypoplastic.

The adult type consists of a localized constriction at or below the insertion of the ductus, rarely above. In only a few cases does the ductus remain open. The aorta is usually dilated above the constriction and narrowed below it. The most common associated anomaly is the bicuspid aortic valve. There is often an abnormal pulsation in the neck. There is usually a systolic murmur best heard in the left infraclavicular region and the upper dorsal region to the left of the spine. If the murmur is carefully timed, it will be found to extend into diastole; in fact, I have recorded phonocardiographically a continuous murmur in cases of this type. The blood pressure is variable, but is characteristically higher in the arms than in the legs, although it may be unobtainable in the left arm when the subclavian artery is involved. On roentgen examination, the ribs are usually notched (from dilated, tortuous intercostal arteries); the heart may be enlarged; the aortic knob is usually decreased or absent, and the ascending aorta dilated.

In 1944 Crafoord and Nylin[7] of Stockholm first reported resection of the constricted portion followed by an end to end anastomosis. The same type of operation has been performed in this country by Gross[6c,d,e] and others. Gross has now operated upon more than 20 patients with a mortality rate of about 15 per cent. All of his surviving patients have had a satisfactory drop of blood pressure in the arms with a rise in the legs. Smithwick[8] has performed dorsolumbar sympathectomies on 6 patients too old to be acceptable for resection, and on the whole they have done well. Blood pressure in the upper extremities decreased, the feet became warmer, and intermittent claudication disappeared in the 1 patient I saw.

Combined congenital defects are more common than single ones, and tetralogy of Fallot is the most frequent combination. It consists of an interventricular septal effect, dextroposition of the aorta, pulmonary stenosis and right ventricular hypertrophy. There is usually a loud systolic murmur maximal in the second to fourth interspaces near the left sternal border. The electrocardiogram shows right axis deviation of considerable degree. It is readily confused with the Eisenmenger complex, which is similar except for the absence of pulmonary stenosis and occasionally the presence of pulmonary insufficiency. The differentiation is important because the operation reported by Blalock and Taussig[9] in 1945 is based upon shunting the blood through an artificial ductus around the stenotic pulmonic valve, thereby increasing the pulmonary circulation. If the pulmonary blood flow is adequate, the operation is contraindicated. Sometimes catheter studies are necessary to determine pulmonary blood flow and pressure.

The Blalock procedure consists of anastomosis of a systemic artery (the innominate, carotid or preferably the subclavian, if the latter is large enough) with the right or left pulmonary artery. The series of Blalock and his associates[10] now comprises 541 cases with an overall mortality rate of approximately 17 per cent. The mortality in those in which they were able to do an end to side anastomosis between the subclavian and pulmonary arteries has been about 10 per cent.

With the aid of an ingenious clamp, Potts, Smith and Gibson[11] modified Blalock's procedure by making a direct side to side anastomosis between the aorta and pulmonary artery. They now have completed 66 operations with a total of 6 deaths.[12] Most of their patients have been tremendously improved and have been able to lead normal lives.[13]

The fourth group of patients is that with anomalies of the aortic arch and symptoms of compression of the esophagus, trachea, or both. Symptoms usually begin early in the neonatal period and persist. Esophageal compression is associated with dysphagia, which may be manifested by a hesitation in swallowing, discomfort during swallowing, spitting of uncurdled milk shortly after ingestion, or refusal to take food in anything but small amounts. Tracheal compression is associated with an increased respiratory rate and various degrees of stridor with loud, crowing inspiration, suprasternal and intercostal retraction and hyperextension of the head. These patients have frequent respiratory infections. Direct laryngoscopy or roentgenograms after lipiodol injection may be helpful in the diagnosis of tracheal obstruction. A barium swallow may reveal compression of the esophagus.

When there is a double aortic arch, the smaller (usually anterior) arch is divided. Gross has performed 5 operations with 3 recoveries in cases of this type. If the right subclavian artery arises from the left side of the aortic arch, it may be severed without impairment of the blood supply to the arm because of the branches from its

second and third portions. Gross and Ware[17] have performed this operation successfully on three occasions. When there is an anomalous origin of the innominate artery, the anomaly may be corrected by displacement of the vessel to a more anterior position.

Sweet and his associates[14,15] have performed 3 successful operations on patients with anomalous aortic rings without a fatality.

I now have several patients with tetralogy of Fallot who were operated upon successfully by Blalock. Only 1 more or less typical case of this anomaly will be presented. Three other illustrative cases are reported.

REPORT OF CASE

Case 1.—C. B. B., a 2 year old girl with tetralogy of Fallot, was operated on on Jan. 2, 1947. Cyanosis appeared about three days after birth and persisted. The patient was somewhat dyspneic, but had no other symptoms.

Physical examination revealed an extremely small cyanotic infant. There was grade I clubbing of the fingers. The second pulmonic sound was greater than the second aortic sound. There was a grade I pulmonic systolic murmur, and grade II systolic murmurs along the left sternal border and at the apex. Roentgenograms revealed clear lung fields. The electrocardiogram showed extreme right axis deviation.

There was immediate improvement after operation. The child soon began to develop and talk and six weeks postoperatively she was walking. She now shows only slight cyanosis at times. There is a grade II to III continuous murmur, heard best in the right infraclavicular region, but well heard in the back, caused by the artificial ductus produced by operation. There is a grade II apical systolic murmur heard along the left sternal border.

Roentgenograms of the chest now show increased vascular markings. The red blood cell count, which was 10,400,000 before surgery, was reduced to 6,400,000 after surgery. The hemoglobin was reduced from 24.3 to 18 Gm.; the hematocrit reading from 74.2 to 58.4 cc. per hundred cubic centimeters of blood. Arterial oxygen saturation increased from 50.2 volumes per cent to 70.6 volumes per cent. The arterial oxygen content was increased and the oxygen capacity decreased.

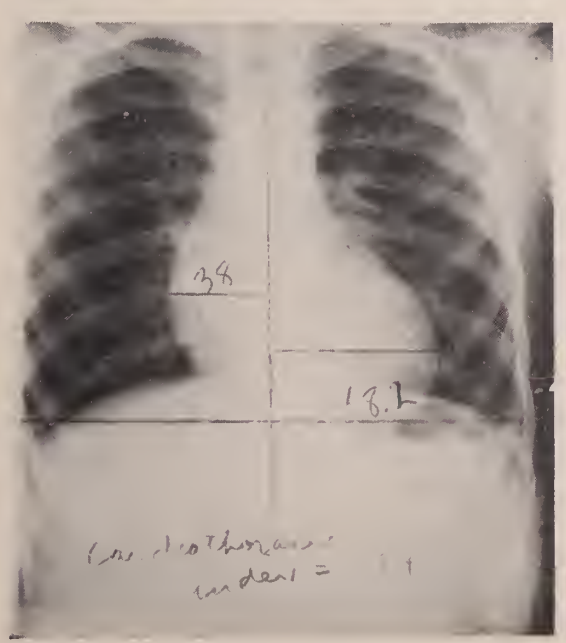
This child had spontaneous fractures of the femur and os calcis after surgery. This interesting complication may occur in a patient who cannot walk before operation, gains weight and begins to walk early after surgery. The underdeveloped bones may not withstand the sudden strain.

Case 2.—A. L., aged 4, was first seen on May 20, 1947 because of a murmur. There were no symptoms other than frequent colds. The blood pressure in the right arm lying was 82/0; left arm lying 78/0. The left border of cardiac dulness was just inside the anterior axillary line. There was a grade IV systolic murmur with a thrill and a grade III diastolic murmur maximal in the second left interspace near the sternum. There were grade III systolic and diastolic murmurs at the apex. The electrocardiogram was noncontributory. Roentgenograms revealed increased pulmonary vascular markings, prominence in the region of the pulmonary artery and cardiac enlargement.

It was my impression that the child had a large patent ductus arteriosus with sufficient left ventricular enlargement to produce relative mitral insufficiency and stenosis. She was operated upon on August 22 by Dr. Gross. There was immediate improvement in general appearance. The heart decreased in size, and the apical murmurs disappeared.

Case 3.—(Fig. 1) P. A. Mc. was a 6 year old girl seen because of a heart murmur first heard at 9 months of age. There were no symptoms except frequent colds. Cyanosis was noted on one occasion following a tonsillectomy.

The child was small for her age. A grade V systolic murmur and thrill were present in the aortic region.



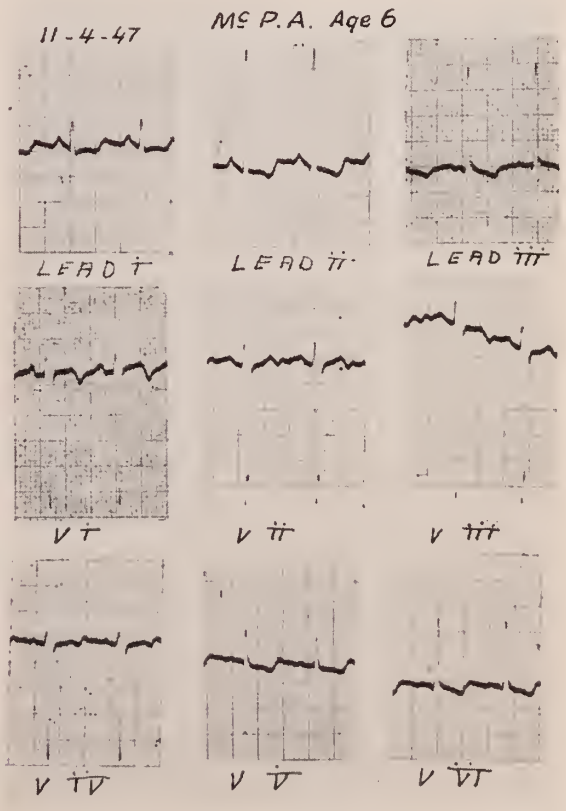


Figure 1

There were grade III systolic and grade II diastolic murmurs at the apex. A systolic murmur was well heard in the back down to the lumbar region. The blood pressure in the right arm lying was 130/80-0; left arm 130-118/100-96-0. The femoral pulse was barely palpable, and the blood pressure in the leg was 76/50. The second pulmonic sound was greater than the second aortic sound. The electrocardiogram was abnormal and indicative of left ventricular and possibly right ventricular enlargement. The heart was slightly enlarged, especially in the region of the left ventricle.

This child doubtless has coarctation of the aorta, probably associated with other lesions, possibly a bicuspid aortic valve and relative mitral stenosis and insufficiency. She deserves further study. Resection of the coarctation is indicated in any event because it will relieve some of the strain on the left ventricle.

Case 4.—(Fig. 2) L. B., aged 9, was extremely cyanotic at birth and remained so until 4 years of age. Since that time she has been less cyanotic, cyanosis appearing only after exercise, excitement or respiratory infections. She has had more respiratory infections than the average child.

Physical examination revealed a slightly cyanotic child. There was slight clubbing of the fingers. The blood pressure was 90/66 in the right arm and 90/64 in the left arm. The left border of cardiac dulness was in the fourth interspace just outside the midclavicular line. The second pulmonic sound was plus, split and greater than the second aortic sound. There were grade III pulmonic and apical systolic murmurs. There were possible short pulmonic and apical diastolic murmurs.

Fluoroscopy of the chest revealed enlargement of both ventricles and moderate enlargement of the left auricle. The pulmonary artery was slightly enlarged. The electrocardiogram was bizarre and showed impaired intraventricular and auriculoventricular condition. The red blood cell count was 4,510,000 and the hemoglobin was 92 per cent.

A large interventricular septal defect could account for all findings and is the probable diagnosis. There may be associated defects, however, secondary to the major defect; for instance, relative pulmonic insufficiency. This patient is not a candidate for surgery according to the present state of knowledge; there is no means of repairing interventricular septal defects. Assuming this diagnosis is wrong, the patient is still not a candidate for surgery because she does not fall in any of the groups known to be helped by surgery.

SUMMARY AND CONCLUSIONS

Congenital heart disease with special reference to defects and combinations of defects amenable to surgery is discussed.

Four cases of congenital heart disease are presented: 1 of patent ductus arteriosus and 1 of tetralogy of Fallot, in both of which the operation was successful; 1 with a large interventricular septal defect, which should not be subjected to operation; and 1 complicated case of coarctation of the aorta, which should be helped by surgery.

It is usually possible to make a specific diagnosis without recourse to catheter studies, but sometimes these are necessary.

Usually one can determine whether or not a patient is a good candidate for surgery, with or without exact knowledge of defects present, but catheter studies may be needed.

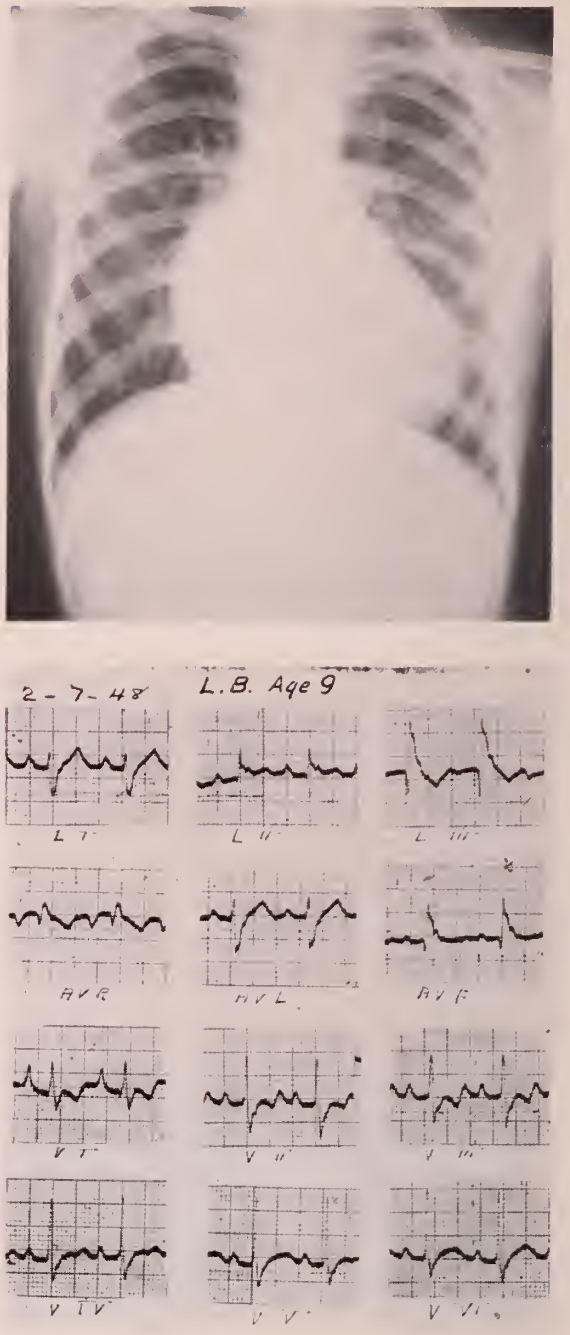


Figure 2

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320 North Main Street.

Saddle Block Analgesia for Obstetrics

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Lake City

"Analgesia and anesthesia are important medical treatments to anyone who is in pain. The parturient woman is justified in her demand for relief from the pains of labor and of delivery if it can be given without endangering her life or the life of her baby. No doctor is justified in refusing pain relief to the woman in labor, and no doctor is justified in using analgesia and/or anesthesia to a degree which is dangerous to the life of the mother or the baby. The numerous methods of analgesia for labor would indicate that none is satisfactory. This is not true. There are several methods that the experienced obstetrician can use to give amnesia-analgesia to 85 to 95 per cent of the women in labor. Anesthesia for the delivery is a more precise procedure and depends entirely on the presence of one qualified to administer the anesthetic of choice.

"The doctor must always remember that any interference with the normal course of labor—hypnotics, oxytocics, anesthetics—increases the hazards for mother and baby. Continuous caudal analgesia has been used in several thousand cases, but is not the optimum type of analgesia and anesthesia. It requires considerable skill and has no potential dangers that cannot be completely eliminated. Spinal anesthesia has been used for many years, and although it too, is potentially dangerous, it requires less skill in actual administration than does continuous caudal analgesia."[1]

"Adriani and Roman-Vega coined the term "saddle block" to describe a technique which provides anesthesia limited to the saddle area (inner thighs and perineum). 'The term is well chosen for it is not only descriptive but does not bear the connotation to the patient that the term "Spinal" does.' "[2]

Ever since there appeared an article in McCall's Magazine early in 1946 dealing with saddle block anesthesia for obstetrics there has been an increasing demand for this procedure. More recently an article in the June 1948 issue of the Ladies Home Journal by Dr. Beatrice E. Tucker, Director of the Chicago Maternity Center, has seemed to stimulate interest in this type of obstetric analgesia. In response to this growing demand my associates and I have made an attempt to evaluate this type of anesthesia.

The obstetric service at Lake Shore Hospital through the period of October 1946 to October 1948 has seen the delivery of 1,213 patients. Quite a number of these women have borne twins. The deliveries have been handled by seven different physicians.

Of 270 patients delivered by one of these physicians, a group of 57 have been delivered with the saddle block technic as developed by Adriani and Roman-Vega,[3] which was adapted to obstetrics by Parmley and Adriani.[4]

The anesthetic drug used was nupercaine 2.5 mg. in 1 cc. of 5 per cent glucose solution. The patient was allowed to sit on the side of the bed or the delivery table with the feet resting in a chair, the arms folded across the chest or resting on the knees and the shoulders supported by a

Read before the Northwest Medical District Meeting, Live Oak, Oct. 18, 1948.

nurse standing in front of her. The back was prepared with alcohol, followed by ether and a mercurial tincture. Local infiltration of the skin and deeper tissues was by a 1 per cent novocain solution, usually about 3 cc. being used. The spinal puncture was made usually in the fourth lumbar interspace, but when difficulty was met or when a dry tap was made, a second puncture was done in the third space. A short-beveled 22 gage spinal puncture needle was used. The spinal tap was made during an interval between uterine contractions.

As soon as a free flow of clear spinal fluid developed, the syringe containing the nupercaine solution was attached and the injection given fairly quickly. The spinal needle was immediately removed, and the patient was allowed to sit upright for some thirty to forty-five seconds before she was placed on her back with a pillow under her head to keep the neck sharply flexed.

Usually within a very few minutes, three to eight, there was a loss of pain sensation in the perineal area, and gradually a satisfactory surgical analgesia developed throughout the lower extremities and midway between the umbilicus and the costal margin. It was found that very small doses of nupercaine in glucose gave a very satisfactory analgesia lasting for one and one-half to three hours.

In our small series of cases there were 32 multiparas and 25 primiparas. The reaction of the multiparas apparently was more satisfactory than that of the primiparas. This reaction was no doubt due in part to the fact that in their former deliveries these women had been given ether, or some other inhalation anesthetic, recovery from which in many cases had been accompanied by nausea and vomiting.

The patients receiving the saddle block analgesia were rarely nauseated and did not vomit after delivery. Eleven of our patients were given very small amounts of ether during the application of outlet forceps or while episiotomy was being done. The ages of the patients varied from 15 years to 47 years. The multiparas had had from one to nine previous deliveries. It was noticeable that the women who had been more frequently delivered were the ones who more enthusiastically commented on the efficacy of the procedure. There were 3 Negro patients, 1 of whom was a primipara.

There were two sets of twins in the series, one of girls and one of identical twin boys. It was of interest that the male twins approached more nearly the average weight for infants (7 pounds 14 ounces and 7 pounds 3 ounces) and that the girls' combined weight approximated that of a single full term infant (3 pounds 4 ounces and 3 pounds 15 ounces).

In this series there was one frank breech, in which delivery was almost as easy as for presentations in the cephalic position.

These 57 deliveries resulted in 57 living babies and 2 dead babies. One of the dead babies was a macerated fetus, seven months gestation, that had been diagnosed as a dead infant by x-ray examination. In this case labor was induced and the saddle block technic used in order to minimize the pain for the mother, who was a thyrotoxic multipara. The second dead infant was an anencephalic monster. An interesting point about this case was that the mother had given birth several years previously to an infant with a severe spina bifida. In this series there were 6 cases in which there was a drop in blood pressure sufficient to produce nausea and faintness. The immediate administration of adrenalin overcame this difficulty, and in only 1 case did the mother vomit more than once while on the table.

In no case has there been any serious complication. Postpartum headache requiring treatment occurred in only 4 patients. We observed no instances of tachycardia, and, as previously stated, none of the patients suffered nausea or vomiting after they left the delivery room. Postpartum catheterizations were no more frequent than in those patients delivered under general anesthesia. To date we have observed no postspinal neurologic sequelae. There have been no deaths in the series. In no case have we observed phlebitis or periphlebitis. One patient receiving a supplementary inhalation of anesthesia had some respiratory irritation which disappeared before she left the hospital, five days postpartum.

COMMENT

Saddle block analgesia with a hyperbaric solution of nupercaine offers definite advantages to a large number of mothers and babies. The small amount of the drug used makes it a safe procedure. The technic is readily applicable in any hospital, large or small. The application of outlet forceps and the repair of episiotomy are facilitated.

SUMMARY

A series of 57 cases in which the patients were delivered under saddle block analgesia is reported. The series, while small, compares most favorably with those in which delivery took place under inhalation anesthesia.

A hyperbaric solution of nupercaine was used in all these cases, and the technic of Parmley and Adriani[4] was followed closely. The spinal punctures were all done by the same physician.

There were 57 patients delivered of 59 infants with a corrected infant mortality of zero. Maternal morbidity was minimal, and there was no maternal death.

Spinal anesthesia can be employed by an experienced physician. In this series of cases the anesthetic proved to be easily administered, was safe, and was desirable for vaginal deliveries.

Continued use of saddle block analgesia seems justified.

When this paper was read, the author stated that certain facts were purposely omitted from the body of the paper in order that pertinent discussion could be developed. Dr. L. G. Landrum brought out pertinent data relative to the physics involved in spinal anesthesia together with the time factor in relation to the amount of cervical effacement and dilatation which determines the time for injection.

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27 West Madison Street.

Management of Cholecystitis

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DETROIT

The management of cholecystitis requires the utmost in medical and surgical judgment. The internist and general practitioner, who usually are the first to see the patients with this disease, must use extra care in the diagnosis and in the advice given to these patients.

Graham provided a powerful diagnostic weapon when he introduced cholecystography. This made it possible to demonstrate a high percentage of nonopaque stones and to give an idea as to the concentrating and emptying power of the gallbladder. When stones were demonstrated roentgenologically, my associates and I found them in 100 per cent of the cases in which an operation was performed in the last five years. In this series we did not find stones in any of the gallbladders reported normal on roentgen examination, although the literature reports errors of 10 to 15 per cent in this group. Stones were found in 86 per cent of the gallbladders not visualizing in roentgen studies and in 67 per cent of those showing impaired function.

From the Brooks Clinic, Detroit.
Read before the Staff of the Tampa Municipal Hospital, Tampa, March 9, 1948.

In patients with roentgen evidence of stone or with nonfilling or poorly functioning gallbladders and a definite history of colic or chills and fever with tenderness and spasm, surgery should not be long delayed. These patients should be operated upon during a quiescent period if possible. The mortality in this group is practically nil unless there are outside complications such as cardiac decompensation.

If, however, surgery is not advised or is refused, the patient is then exposed to a number of serious complications. The patient with gallstones, even though symptomless at the time, is always under threat of further attacks. We have done emergency operations on the gallbladder of a considerable number of patients 70 to 90 years of age who were advised twenty years previously that they were too old for operation. Had these patients been operated upon during quiescent periods, they would have avoided the dangers of perforation, common duct stone, associated hepatitis or pancreatitis with the possibility of pancreatic fat necrosis. One must also remember that 95 per cent of carcinoma of the gallbladder

is associated with stones. The dangers are well illustrated by Jaguttis, who followed 114 patients with cholelithiasis treated conservatively for ten to twenty-five years. In 5 cases carcinoma of the gallbladder developed. In 13 cases the patient died of cholecystic disease. There were complications necessitating operation in 25 cases, with 4 deaths. It must be pointed out that the incidence of carcinoma in this series is high. This is, however, a mortality rate of 19.3 per cent as compared with our results in the last five years in which the mortality rate for all biliary tract operations was 2.8 per cent and for cholecystectomy alone was 0.7 per cent.

It is of the utmost importance that patients suspected of having cholecystitis should have an electrocardiogram, roentgenogram of the chest, complete roentgen study of the gastrointestinal tract and Graham test. Jaundice or acute cholecystitis is a contraindication for the Graham test. It is also not wise to perform many of the other tests in the emergency case, but an anteroposterior roentgenogram of the chest and one of the abdomen and an electrocardiogram can be obtained in all cases. We have decided on these tests after having some puzzling cases of gallbladder disease associated with diaphragmatic hernia, gastric and duodenal ulcers, carcinoma of the stomach, pancreas, ampulla of Vater and transverse colon, duodenal diverticula, pneumonia of the lower lobe of the right lung and appendicitis in a high appendix, especially if it is retrocecal.

Coronary disease and disease of the gallbladder are frequently confused and, to add to the confusion, they frequently occur in the same patient. Previous coronary thrombosis or moderate changes in the electrocardiogram are not contraindications to surgery for gallstones. We have seen several patients having anginal attacks who had fewer or no attacks following removal of gallstones. The internist and the surgeon working in close cooperation will usually be able to give the patient good advice.

Preparation of the acutely ill patient is especially important. Our plans are made on a twelve to twenty-four hour basis. An acutely ill patient coming into the hospital one day is scheduled for operation, as a rule, the following morning. Should he improve under hospital care, his operation is postponed another twenty-four hours. This postponement might continue for several days, and sometimes the patient is sent home to complete his recovery and to have his operation at a quiescent period. Rarely is it necessary to operate on patients in this group except during regular operating hours.

In the preparative period we attempt to achieve fluid balance, to correct chloride deficiencies and to supply the patient with vitamins C, B and K. The duodenal tube is used for distention or vomiting, and frequent small blood transfusions are given the anemic or jaundiced patient. If the patient does not continue to improve under this regimen, then emergency surgery is performed.

One thing of which we are strongly convinced is that academic cholecystectomy in all patients is dangerous. The time to decide on the type of operation to be done is when the pathologic condition is exposed and then only with consideration of all the known factors. When exposure is difficult, we like to aspirate and open the gallbladder; then with the finger in the gallbladder or a probe in the cystic duct dissection is facilitated. When dissection of the ducts is difficult, cholecystostomy is still a good operation. The gallbladder may be packed with gauze and left open for nature to perform its own cholecystectomy. This may often be done without ligating a single vessel. Even though the gallbladder is removed, we sometimes insert a tube through the cystic duct into the common duct for drainage.

The gallbladder should never be removed until one has made certain that the common duct is patent. If doubt exists, then a simple drainage should be done. If obstruction is due to edema and inflammation, it will then rapidly subside and the patient improve. Should the obstruction persist, the cholecystostomy is then regarded as the first stage in preparing the patient for radical removal of the obstruction, should it be a resectable malignant lesion. In nonresectable lesions the gallbladder may be used in short-circuiting biliary drainage by anastomosis with the gastrointestinal tract. In this regard we cite the work of Cattell at the Lahey Clinic, who not only has been reestablishing the biliary tract in nonresectable lesions but anastomosing the pancreatic duct to the jejunum. By this procedure the nutrition of the patient is greatly enhanced.

We greatly prefer spinal anesthesia in our cases and use it whenever there are no contraindications. In the seriously ill patients local block and infiltration anesthesia is frequently combined with pentothal or gas inhalation. The choice of anesthesia should depend upon the condition of the patient, the operating speed of the surgeon and the anesthetist available.

Until about ten years ago we used a longitudinal incision. In a number of patients who had been subjected to previous operation we found that a troublesome postoperative hernia would develop in the gallbladder incision or in the other incision. Since this was thought to be due to nerve damage, it seemed logical to use a transverse incision in such cases. Our experience with this incision was so satisfactory that we now use it almost routinely. If there has been previous biliary tract surgery, we tend to use the same incision and excise the old scar.

After a careful and thorough examination of the common duct and the performance of any needed surgery on that organ, our attention is given to the gallbladder. We prefer to ligate doubly and separately the cystic duct distal to the ligature so that scar tissue will not cause obstruction to the common duct later. Practically all common ducts that are opened are drained. We use a "T" tube, the diameter of which is not over two thirds that of the common duct. The cross bars are not made much longer than 4 cm. in either direction, and the back of the cross bar opposite the long tube is cut away so that the lumen of the tube may be inspected, as occasionally a fringe of rubber may obstruct the tube or give a ball valve action. In all operations on the biliary tract we drain the peritoneal cavity by a soft rubber drain in Morrison's pouch. If a transverse incision is used, the drain is brought out the lateral end of the wound, and if the longitudinal incision is used, a stab incision is made lateral to the main incision.

For a long time our gallbladder patients have been getting out of bed the day following operation. We have had no difficulty with our wounds although we still use catgut in the most of the cases. In the difficult case, however, or when there is malnutrition, obesity or other complication, we favor steel alloy wire for closure.

The "T" tubes are clamped a few days after operation in the uncomplicated cases, and if bile flows satisfactorily into the gastrointestinal tract as shown by cholangiograms, then the tube may be removed. In large, thick ducts the tube may be allowed to remain three to four weeks and in severe hepatitis and pancreatitis it may be allowed to remain four to six months.

The following is a summary of the cases of biliary disease we have treated in the last five years.

SURGERY OF BILIARY DISEASE AT THE BROOKS CLINIC SEPTEMBER 1942-SEPTEMBER 1947

I.	Cases hospitalized		480
	Operations		451
	Sex		
	Females	375	
	Males	105	
	Ratio	3.5 to 1	
	Average age	50.9	years
	Duration of Symptoms		
	More than nine months	328	patients
	Less than nine month	138	patients
	Less than one week	18	patients
	Average duration seven years		
II.	Diagnosis		
	Chronic cholecystitis		431
	Cholelithiasis		401
	Empyema of gallbladder		28
	Acute cholecystitis		27
	Choledocholithiasis		26
	Cholangitis		16
	Gangrene of gallbladder		14
	Carcinoma of gallbladder		7
	Rupture of gallbladder		4
	Hydrops		3
	Dyskinesia		2
III.	Operations		
	Cholecystectomy		406
	Choledochostomy		62
	Cholecystostomy		26
	Cystic duct drainage		21
	Choledochotomy		14
	Cholecystojejunostomy		1
	Cholecystogastrostomy		1
IV.	Anesthesia, incision, hospital stay		
	Anesthesia		
	Spinal	371	
	Nitrous-ether	70	
	Local	10	
	Incision		
	Pararectal	272	
	Subcostal	179	
	Average hospital stay		
	Preoperative, three days		
	Postoperative, fourteen days		
V.	Mortality		
	Operations		451.0
	Deaths		13.0
	Percentage of deaths		2.8

Cholecystectomy alone	332.0
Deaths	3.0
Percentage of deaths	0.9
Causes of death	
Surgical	4
Bile peritonitis	2
Hemorrhage-pneumonia	1
Obstructive jaundice (occlusion of hepatic duct)	1
Cardiac	4
Pulmonary	2
Neoplasm	2
Hepatic failure	1

VI. Morbidity

Complications		34.0
Percentage		7.3
Surgical		
Residual common duct obstruction	7	
Wound infection	3	
Dehiscence	3	
Biliary fistulas	2	
Bile peritonitis	1	
Hematoma	1	
Spinal headache	1	
Pulmonary		
Pneumonia	8	
Pleurisy	3	
Other		
Parotitis	2	
Unexplained fever	2	
Thrombophlebitis	1	

VII. Gallstones

Location	
Gallbladder	352
Cystic duct	156
Common duct	26
Location in jaundiced patients	
Gallbladder	12
Cystic duct	6
Common duct	10

VIII. Complications of gallstones

	Per cent
Jaundice	19.6
Empyema	6.2
Gangrene	3.1
Carcinoma	1.5
Rupture of gallbladder	0.8

IX. Jaundice

Number of patients		Mortality rate Per cent
Present	38	12.0
In the past	54	3.7
Absent	378	1.9

84 per cent of jaundiced patients had stones.

64 per cent of these stones were not in the common duct.

61 per cent of stones in the common duct were not associated with jaundice.

X. Graham-Cole test

	Stones
Normal	0
Nonvisualization	68
Stone	220
Impaired function	10
	No stones
Normal	9
Nonvisualization	11
Stone	0
Impaired function	5
	Percentage with stones
Normal	0.0
Nonvisualization	86.0
Stone	100.0
Impaired function	67.0

113 Martin Place.

RESERVE THESE DATES

APRIL 10, 11, 12, 13, 1949

FOR THE CONVENTION IN

BELLEAIR

Some Safeguards in Antibiotic Therapy with Special Reference to Penicillin and Streptomycin

Joseph Farrington, M.D.
and
J. Frank Wilson, M.D.
Jacksonville

With investigators forewarned by experiences with the sulfonamides,[1a,b] studies of the skin-reactive and toxic factors have paralleled from the beginning the various therapeutic applications of the antibiotics. The relative dangers of drug and disease must in each case be evaluated; hence, knowledge of the various untoward effects following the administration of antibiotics should be more widely disseminated. Clinical classification[1c,2] and also plans for the prophylaxis and management of the various reactions that may be encountered with the more commonly used ones[1d] have been described.

Extensive studies of the value of testing of the skin[1e] or mucous membranes[1f,g,3] as a pre-administration precaution[1h] or for the determination of the various allergic phenomena which may be demonstrated by this means have been reported. Fortunately, toxic manifestations, except deafness from streptomycin and the occasional therapeutic paradox following the treatment of syphilis with penicillin, are largely reversible in that they disappear or tend to subside when treatment is stopped. Extreme variations in the degree of reactivity to these various chemotherapeutic agents are sometimes encountered. Certain expedients, such as the advantage which may be taken of periods of relative anergy for therapeutic action, have been demonstrated.[1i]

The choice of the antibiotic to be used in each case is important. The experience of Florey[4] has enabled him to formulate authoritatively properties desirable in any antibiotic:

(1) It must have a powerful action against at any rate some bacteria. (2) It must have specificity of action. (3) A substance must possess little toxicity to the intact animal body, and the less of this the better. Not only must it lack toxicity to the intact body but also to the individual cells such as leukocytes. It must not damage the kidneys if it is excreted and possibly concentrated by them, and its toxicity must not only be low following a single dose but it must not cause any changes in the body when given in frequent doses for a considerable length of time. (4) A substance must be active in the presence of body fluids such as serum, pus, and cerebral fluid. (5) The chemotherapeutic agent must not be destroyed by tissue enzymes. (6) It should be stable. (7) It is also desirable that it should not be too rapidly excreted by the kidneys. (8) Another property which we have come to recognize as being serious is the capacity to produce in infecting bacteria a resistance to the chemotherapeutic drug itself. This was first noted with the sulfonamide compounds, for bacteria can become resistant to the sulfonamide drugs both in vitro and in vivo. This is especially true of the staphylococcus.

Other organisms sensitive or nonsensitive to various antibiotic agents are now well known.

The need for accurate and repeated bacteriologic diagnosis has, therefore, been increased rather than decreased by the use of antibiotic therapy. When possible, the sensitivity of the organism concerned to the antibiotic selected for therapy should be determined by laboratory assay. The types of organisms responding to a particular antibiotic have been publicized. The danger of upsetting the balance of different pathogenic bacteria normally present in the body has been noted by the use of penicillin and streptomycin. The primary disease may be cured by the antibiotic agents by suppressing bacteria sensitive to their effect, but may permit other bacteria to multiply and become invasive, thereby causing a new disease. Such infections may arise not only from bacteria already present but also from those introduced during therapeutic procedures. This effect sometimes occurs through faulty technic of injection. Unless a separate syringe and needle are used for each patient when several patients are given injections in a series, the transfer from one to another of viruses or organisms nonsensitive to the antibiotic used may result. Cases of post-penicillin jaundice (infectious hepatitis), for example, have resulted from this procedure.

The experiments of Hughes[5] have shown "three possible mechanisms which, either separately or together, might account for this contamination. These are (1) back pressure forcing fluid from the muscle into the needle, (2) spread of blood from the tip of the needle towards the syringe and (3) suction when removing the needle from the syringe aspirating the needle contents back on to the tip of the latter." The combined use of penicillin and streptomycin is to be condemned

because of the possibility of sensitizing patients needlessly against either antibiotic.

Few antibiotics are homogenous products; they contain substances which may cause hypersensitivity or toxicity to develop in patients or personnel handling or administering these drugs. Table 1 shows the types of reactions to antibiotics that have been recorded. Whether the clinician should persist in giving an antibiotic in the face of toxic manifestations is a matter for individual judgment with special regard to prognosis if treatment is discontinued. Because they are devoid of many impurities and tissue irritants, the administration or change to the purer crystalline fractions rather than the more crude amorphous products will eliminate many reactions. The number and severity of the reactions also vary with the particular salt of the antibiotic used. The administration of antibiotics combined with an anesthetic agent eliminates much of the pain and tenderness at the site of injection. The blood levels are comparable to those of earlier preparations. Local or topical use of antibiotics will give rise predominantly to contact dermatoses while parental administration is apt to produce so-called endogenous dermatoses or toxicoses. The unpredictable blood levels when penicillin is administered orally and the dangers of the intrathecal route have been sufficiently emphasized in recent medical literature.

The ease with which epidermal sensitivity can be induced by repeated contact with penicillin has been demonstrated.[1,3-6] Before administration of antibiotics to patients the indications for antibiotic therapy should be clear cut. Patients or personnel with allergic backgrounds or whose skins are in unstable equilibrium because of some exudative dermatitis are poor risks to receive or to administer antibiotics. Likewise, persons with chronic fungus infections are prone to have allergic dermatoses from penicillin. This result has been realized since Schnurman's report[7] of 5 patients in whom a reactivation of an old latent trichophyton infection occurred during the course of penicillin therapy. Peck, Siegal and Bergamini[8] stated that 5 per cent of the patients showing penicillin sensitivity do so as the result of such an association. Although the exact mechanism has not been de-

TABLE 1

REACTION	TOXICITY	HYPER-SENSITIVITY	ENCOUNTERED WITH PENICILLIN	ENCOUNTERED WITH STREPTOMYCIN	INDICATION FOR DISCONTINUING THERAPY
Chills, fever, headache, flushing of face, muscle cramps, nausea, vomiting, transient azotemia, eosinophilia	Yes	No	Yes	Yes	No
Disturbances in sexual cycle or puerperium	Yes	No	Yes	No	No
Pain at site of injection	Yes	Yes	Yes	Yes	No
Skin and/or mucous membrane eruptions	No	Yes	Yes	Yes	Depends on severity
Reactivation of old latent fungus infections	No	Yes	Yes	No	No
Neurotoxic eighth nerve disturbances, namely, vertigo, tinnitis, and deafness	Yes	No	No	Yes	Yes
Mental aberrations, namely, mania, depression, syncope, convulsions, peripheral neuritis, pleocytosis	Yes	No	Yes	Yes	Depends on severity
Herxheimer reaction	Undetermined		Yes	No	Depends on site and severity
Bronchial asthma	No	Yes	Yes	No	Yes
True anaphylactic shock	No	Yes	Yes	No	Yes
Hydrarthrosis	No	Yes	Yes	No	No
Angiitis; vascular thrombosis	Yes	Yes	Yes	Nc	Yes
Increased coagulability of blood	Yes	No	Yes	Yes	No

termined, the eradication of a previously existing fungus infection or the withholding of elective penicillin therapy in these cases is an important safeguard until the patients have been desensitized to penicillin. Investigators so far have been unable to show any relationship between previous fungus infections and streptomycin sensitivity.

Unless more careful selection of hospital and laboratory personnel is made and their indiscriminate contact with these agents is avoided, an increasing number of hypersensitivity reactions is inevitable. Strauss and Warring[9] recently reported epidermal sensitization occurring in 6 of 12 nurses handling streptomycin.[10] Reports of cutaneous eruptions observed by other investigators include one by the National Research Council of cutaneous eruptions occurring in 49 of 1,000 cases reported. Canizares and Shatin[11] reported a case of dermatitis venenata involving the hands, forearms and face occurring in a nurse while handling solutions of streptomycin. Positive reaction to skin tests was obtained in this case. Unless more careful selection of personnel is made and more stringent safeguards are exercised, epidermal sensitization to antibiotics will become a definite occupational or professional hazard.

The application of antibiotics to the treatment of venereal diseases is well established and is finding a wider application.[12] The knowledge and use of proper safeguards in this connection may literally be life-saving in several circumstances. A diagnosis of syphilis is often confused by the administration of penicillin for the treatment of other diseases. Failure to do darkfield examinations or to make adequate serologic follow-up will in many cases result in failure to detect those cases of syphilis complicating gonorrhea treated with penicillin. All of the patients in this group should be subjected to monthly serologic examinations for at least four months thereafter.

The problem of managing a patient previously treated with penicillin for pneumonia or some surgical infection who is then found to have a positive serologic test for syphilis is a difficult one. A decision must be made as to whether further treatment for syphilis is indicated. A sharp febrile reaction within the first twenty-four hours after administration of penicillin for gonorrhea, or other acute infections, suggests a concurrent syphilitic infection. If such infection is thought to be present, decision rests on the clinical type and on examination of the blood and spinal fluid as well as on the amount of penicillin already given and the manner in which it was administered. In general, if such a patient has not received the minimum amount of penicillin suggested for the adequate treatment of that particular type of syphilis, he should be retreated.[13]

Herxheimer reactions either local or general follow frequently when syphilis is treated with penicillin. The injection of this antibiotic results in the destruction of a large number of spirochetes with the liberation and absorption of their proteins or endotoxins. A consequent Herxheimer reaction may cause a fatal coronary occlusion when there is cardiovascular involvement. If there is extensive cerebral vascular or cortical involvement in neurosyphilis, the sudden edema and infiltration of the vessels may cause cerebral hemorrhage or precipitate an acute paresis. A patient with acute edema of the larynx as a manifestation of a Herxheimer reaction may require an emergency tracheotomy. These severe constitutional reactions and unpredictable local effects should be guarded against by initiating treatment with small doses of penicillin or by a thorough preparatory course of bismuth. The latter procedure is perhaps safer.

Recent published evidence indicates that both penicillin and streptomycin may produce changes in the coagulation time of the blood.[14] In 1945 Moldavsky, Hasselbrock and Cateno[14] found that in patients under treatment with penicillin the clotting time was definitely shortened after an injection. Other investigators have shown that in cases of hemophilia, however, no shortening of the coagulation time resulted. Streptomycin also has the effect of increasing the coagulation time for a considerable period. Both in cats and rabbits the thromboplastic action of penicillin can be overcome by suitable doses of dicumarol. At present it is thought that the danger of thrombosis in human clinical practice is probably small. Nevertheless, such cases have already been recorded. Frada,[14] according to a comment in the Lancet recently, described a series of 4 cases in which embolic accidents occurred, and he attributed them to the action of penicillin in increasing the coagulability of the blood. Whether dicumarol or other anticoagulants should be used in susceptible patients during antibiotic therapy is still a moot question.

Reports of ill effects in human beings from clinical use of other antibiotics are few. Even extremely small amounts of tyrothricin in the cerebrospinal fluid, however, may produce disastrous effects. Tyrothricin irrigation of infected cavities near the subarachnoid space is to be

avoided. Chemical meningitis in 2 cases with 1 death has recently been reported by Otenasek and Fairman[15] following this procedure.

SUMMARY

Relative dangers of drug and disease must always be evaluated. Knowledge of the prophylaxis and management of the untoward effects following the administration of antibiotics should be more widely disseminated. The choice and dosage of the antibiotic to be used in each case is important. The need for accurate bacteriologic or venereal diagnosis has been increased by these agents. The use of anticoagulants during antibiotic therapy is still a moot question.

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WILL OUR LEADERS GIVE US A CONSTRUCTIVE PROGRAM ADEQUATE TO FIGHT COMPULSORY HEALTH INSURANCE?

Now that the national election is over, we can begin to see ahead through thinning fog and smoke. Perhaps we should pause to count the casualties and reappraise the position of the medical profession in this country.

President Truman's re-election, the congressional shift toward strong Democratic majorities in both houses, and the replacement of many conservatives by so-called liberals portend a concerted drive for the objectives of governmental compulsory health insurance.

Writing under the caption "Despite Lessons of Experience," Dorothy Thompson recently had this to say about compulsory health insurance:

> The United States Public Health Service is for [a compulsory health insurance bill], as every Government Agency is always for vast expansion of its powers. The labor unions and farmers' organizations are for it because it sounds good. Industry would like to saddle the Federal Government with the expense of workmen's compensation cases. Professional social workers foresee great opportunities for themselves. And a mere 150,000 physicians, 90% of whom are against it, cannot buck the trend. . . .

Many months ago, Dr. Paul R. Hawley pointed to the trend and gave fair warning that the threat was imminent. Using strong language he said:

> But my heart grows heavy as I see the indifference of many physicians to the threat to freedom in medicine that is becoming more menacing each day; and as I encounter the petty, selfish greed of a few physicians who had rather see the entire structure of American Medicine wrecked than to concede one small personal advantage in the general interest.

To replace negative action, Dr. Hawley offered a program of positive force—an adequate, comprehensive Blue Shield-Blue Cross program with central coordination and wider coverage. But with what result? More negative action.

There appear to have been three big fears in the minds of physicians: first, some have appeared to be afraid of any change whatever and have wanted to keep the status quo; second, some have been afraid that Blue Cross wants to practice medicine; and third, others have feared the loss of local autonomy in favor of national control.

With regard to the first fear and the desire to maintain present conditions in status quo, we need only to open our eyes to reality to be convinced that that position is neither tenable nor desirable. Most fair-minded physicians readily grant that we need better health service; more genuinely free medical service for people in true need; more hospitals; and more public aid for existing hospitals inasmuch as the sources of private support are being drained off in increased taxes.

The second fear seems unfounded and can, we believe, be dismissed, but the third fear embraces an important issue which we should do well to

study and ponder carefully: the age-old conflict between local and national control.

The Oregon State Medical Society and others, no doubt, have rendered great service by pointing out the difficulties and dangers involved in the Blue Cross-Blue Shield organization at a national level rather than at local levels, but to date the result appears to have been a stalemate, that is, more negative action from our leaders. Meanwhile, more and more time is wasting.

We can present all the logic and give all the reasons why compulsory health programs are not good: they cost the people too much; they provide inferior service at a high price; they are incapable of dealing with complicated and really serious illnesses; they build up a vested interest of bureaucrats of which the people will never rid themselves, et cetera. There seems no logical reason whatever for this great inventive country founded by rugged individuals, proud of their freedom from regimentation, to adopt social measures which have originated and proved unsuccessful elsewhere.

We are told, however, that this issue is apt to be settled not by reason, but by emotion. If this is as it seems in a large part true, we cannot afford to delay positive action longer.

The recent action of the American Medical Association at its Interim Session in St. Louis in assessing each of its 140,000 members $25 to raise a fund to provide a nationwide educational program and to oppose any government-controlled health plan is a good step in the right direction. But we need to do more than oppose and we need to have more to present to the public for their education. We hope that our leaders will come forward promptly with a clearcut constructive plan of positive action.

ONCE IN A HUNDRED YEARS
THE AMA ASSESSMENT

For the first time in its century of existence the American Medical Association, by the unanimous action of its House of Delegates at the recent Interim Session in St. Louis, levied an assessment on its 140,000 members of $25 each. The fund of between two and three million dollars thus created will be used to promote a nationwide plan of education on the progress of American medicine, stressing the importance of the conservation of health and the advantages of the American system in securing a wide distribution of a high quality of medical care.

In making the assessment, the House of Delegates reaffirmed its stand against so-called socialized medicine and against any form of compulsory sickness insurance as proposed in the recent distorted report by Federal Security Administrator Oscar R. Ewing. In a statement which followed action by the House, the Board of Trustees pointed out that this report by Mr. Ewing, entitled "The Nation's Health," is a complete departure from the conclusions of the 800 interested leaders in the field of health, agriculture, industry and welfare who attended the National Health Assembly called by Mr. Ewing last May.

Notification to secretaries of state medical societies stating that "you are requested to collect this assessment through your county units" brought prompt response from many state societies that they would lend wholehearted cooperation. The promptness with which checks began arriving at headquarters, some of them for $50 instead of $25, indicates the desire for action on the part of doctors everywhere and their willingness to support "this show of new virility and life in our great association," as one state secretary expressed it. The explanation which was mailed to every member of the Florida Medical Association as this Journal was going to press is of course expected to bring prompt and ready response.

A planning committee of ten members will govern the over-all policies of the campaign. The public relations firm of Whitaker and Baxter of San Francisco will serve as public relations counsel, directing the entire campaign from offices in Chicago and Washington. Mr. Whitaker and Miss Baxter directed the campaign of the California Medical Association which defeated the program of compulsory health insurance proposed in that state by Governor Earl Warren.

Mr. Whitaker has announced that the public education campaign of the American Medical Association will be built around the following three objectives:

1. To awaken the people to the danger of a politically controlled compulsory health insurance system.

2. To acquaint the people with the superior advantages of American medicine over the government-dominated medical systems of other countries.

3. To stimulate the growth of voluntary health insurance systems and prepaid medical care plans to take the economic shock out of illness and increase the availability of medical care to the American people.

It will doubtless be necessary to utilize all of

the usual mediums of public education in this endeavor. Emphasis will be placed on the ideals of the American medical profession. There is every assurance that the special Coordinating Committee for the Protection of the People's Health, composed of members of the Board of Trustees and of the House of Delegates, is proceeding and will continue to proceed in an orderly, scientific manner to accomplish the vital task assigned it by the House of Delegates of the American Medical Association.

WHAT IS PUBLIC RELATIONS?

What does public relations mean to you? Merely publicity? Narrowing the definition further, only press relations? Or is your conception of it broad enough to include everything said or done by an organization and those associated with it? No two physicians would perhaps define it alike. This last appraisal would doubtless be submitted least often; yet, upon reflection, this evaluation covers exactly what it is.

Public relations then means everything you say or do—everything that has its effect on the public. The difference between public relations and publicity is basic and needs to be clearly understood. How to place your ideas before the public in the most convincing manner is of course important, but the problems facing the medical profession today will not be solved by the press and radio, no matter how favorable the comment. The adoption of a public relations program is no easy panacea. Leaving the grave difficulties which confront American medicine to public relations directors and officers of the various medical organizations is no simple cure-all.

Fundamentally, good public relations for the medical profession depends first upon your understanding the public and the public understanding you, and second upon your meeting the needs of the public for medical service.

And who is the public? The American people are made up of innumerable groups, by no means doing the same things, thinking the same things, and wanting the same things. Some are clearly defined; some overlap. One may be a member of several different groups on different levels. These groups may well represent different publics.

What is the status of your personal public relations with your various publics? Routinely you meet your medical public—colleagues, nurses, technicians and hospital administrative personnel. Daily you meet your patients—the all important public on which your profession and the allied professions depend. There is your government public—legislators and government officials of various kinds. There is your service club public, likewise your social public. If you will stop to evaluate, you will find that you have many publics.

What do your publics expect of you? Have you given special thought to understanding your publics and meeting their needs? It is the grass roots public relations of every individual doctor in this country—everything you say and do that relates to your publics—that will ultimately win or lose the life and death struggle for its freedom in which your profession is now engaged. Nothing supplants the personal equation in the final analysis.

"UNCLE SAM . . . M.D."

American medicine is on the march to establish in the public mind federal compulsory health insurance for the quackery that it is. As one step in the newly launched campaign of public education, "Uncle Sam . . . M.D.," a brochure containing the latest information with which every physician, and indeed every taxpayer, should be familiar, is being mailed to every doctor who is a member of a state medical society.

The following subheadings indicate the scope of the material set forth succinctly in the booklet. What Kind of Health Plan? And Who Shall Run It? Where Did This "Compulsory" Idea Come From? Who Wants Compulsory Health Insurance? What Does S. 1320 Provide? Are We as Sick as Some Say We Are? Those Much-Abused Draft Figures. Is Health a National Problem? Is Health a Matter of Money? Even Medical Care Can't Do It All. How Far Can Prevention Go? How Far Can Voluntary Plans Go? What Do "Compulsory" Proposals Promise? How Much Would Compulsory Insurance Cost? How Many Doctors, Nurses, Hospital Beds? What Happens to the Veterans? Can We Have Compulsion Without Federal Control? What Happens to Quality of Medicine? Where Do We Go From Here?

It has been well said that physicians must either provide leadership or follow leadership. The time is at hand to translate this kind of thinking into action. In so doing, this booklet, and the literature to be sent out as the campaign unfolds and gains momentum, will be of invaluable aid to every member of the profession who would keep abreast of the issues and developments of this movement in which he has a tremendous stake.

MALIGNANT MELANOMA RESEARCH ARMY DOCTORS PLAN INTENSIVE STUDY

Malignant melanoma, which originates from an apparently harmless black mole and kills with lightning speed, is next on the list of research projects to be undertaken by the Army Medical Department. Long an enigma to the medical world, this disease occurs with relative infrequence, but because early diagnosis has seldom been possible and because successful treatment, other than early surgery, has never been found, the Army has decided to make an intensive study of some 400 autopsy and surgical specimens.

This material has been collected over a period of years by the Army Institute of Pathology. Its staff is now preparing thousands of slides for an exhaustive study that may continue five or six years. Pathologists and dermatologists of the Army Medical Department hope that findings will bring a complete histologic understanding of the disease and its manner of growth, and criteria for its recognition in an early stage—before it has had time to pump death into the blood stream.

A mole that has been inconspicuous for years may suddenly grow larger and become deeper in color. A tight collar, a belt, or a shoe may so irritate or bruise a small nevus that inexplicable change in its cellular structure causes it to become malignant. Unless the entire area is removed immediately by surgery, malignant melanoma may speedily claim another victim. Two to four years is the maximum time that one may expect to live after the malignant stage has set in.

Melanoma is one of the many problems on which Army scientists are at work. Other projects of particular interest under way at the present time are studies in radiation injury, carcinoma of the lip, deficiency diseases having dermatologic manifestations, atabrine dermatitis and high altitude frostbite. This type of research is especially to be commended as a legitimate and constructive contribution to medicine and the health of the nation from a government source.

NATIONWIDE INVENTORY OF NURSES

The American Nurses' Association is currently engaged in directing a complete inventory of all professional registered nurses in the United States and its territories. This important undertaking will be accomplished through its 51 affiliated state nurses' associations and through the 52 state nurse-licensing boards. A questionnaire is being mailed to all professional registered nurses, and final tabulation is expected to be complete by next June.

The inventory was requested by the National Security Resources Board, a permanent civilian agency created by the National Security Act of 1947 and composed of Arthur M. Hill, chairman, and the Secretaries of State, Treasury, Defense, Interior, Agriculture, Commerce and Labor. This board, which reports directly to the President of the United States, is charged with the duty of formulating for the President's consideration plans and policies concerning industrial and civilian mobilization in order to assure the most effective mobilization and maximum utilization of the nation's manpower in the event of war.

Maintaining the census of nurses on a current basis will become a permanent routine procedure, predicted Miss Pearl McIver, president of the American Nurses' Association. In peacetime, the inventory would offer invaluable data in over-all planning for the nursing profession, for nursing education and for recruitment.

The most important inventory is, of course, the initial one now under way. Physicians have a special opportunity to help make every nurse in the country realize how vital it is for the military and civilian needs of America that she fill out as soon as possible the census questionnaire sent to her by her state nurse-licensing board.

DR. PRESSLY RECEIVES GENERAL PRACTITIONER AWARD

Dr. W. L. Pressly, a physician of the deep South, was the recipient of the 1949 General Practitioner Award of the American Medical Association. This authority on rural health and sanitation in his state of South Carolina has practiced for thirty-two of his sixty-one years in his home town of Due West. In the county in which he practices, he is known as the "Father of Public Health." Since the day he entered practice he has engaged in the fight against typhoid and has sponsored well baby clinics and comparable measures for keeping the people of the community well.

Dr. Pressly was one of three doctors voted on at the first Interim Session last year for the gold medal award and this year won out over the nominees of twenty-three other state organizations. These general practitioners were chosen by their state medical associations as distinguished physicians, noted in their respective states for their long and devoted service. The Florida Medical

Association was privileged to nominate Dr. Rufus Thames of Milton for this honor. County societies may well keep in mind that they may each nominate a member annually for recognition as the Association's outstanding general practitioner of the year. The general practitioner selected from among these nominees becomes Florida's candidate for the national award.

When he decided to study medicine, Dr. Pressly had to forego a successful baseball career and a salary of $5,000, a munificent sum for those days. He turned down an offer from the Pittsburgh Pirates to enter medical school. He played professional baseball both before and after his graduation in medicine.

A graduate of Erskine College in Due West, he received his medical education at Emory University and served as intern and resident at Jefferson Hospital in Roanoke, Va., from 1912 to 1915. He yielded to the advice and influence of his close friend, Dr. Hugh H. Trout of Roanoke, who urged him to give up professional baseball and devote his life to the practice of medicine. Since returning to Due West more than three decades ago to practice his profession, Dr. Pressly has served as president of the Abbeville County Medical Society, as a councillor of the South Carolina Medical Association from 1933 to 1940 and then as its president, as chairman of the General Practice Section of the Southern Medical Association and of the South Carolina Academy of General Practice, as a member of the executive committee of the South Carolina State Board of Health and during World War II as state head of the Procurement and Assignment Service.

In recounting his experience as a general practitioner to newspapermen after receiving the award at the St. Louis Interim Session last December, Dr. Pressly said, "In entering the medical field, I resolved and have sought rigidly to adhere to one idea—that my life would be one of service to mankind."

SALUTE TO DR. WILLIAM M. DAVIS ST. PETERSBURG'S RECORD KEEPER

It was nearly forty years ago, back in 1911, that Dr. William M. Davis, as city physician of St. Petersburg, undertook complete recording of deaths and births in that city. Except for a few scattered statistics compiled on a hit or miss plan prior to that time, all records since they were first instituted there were compiled in his office until three months ago.

The Davis files had been kept complete for four years on deaths and three years on births when the state of Florida first made provision for such records and established a method and agency for keeping state records. The state law became effective on May 27, 1915. Since that time Dr. Davis has served as local registrar and has forwarded original birth and death certificates to the Florida State Board of Health in Jacksonville. Service twenty-four hours a day seven days a week has been provided.

Since last November these vital statistics have been compiled in the county health department, with all copies of such records available only there or in the offices of the State Board of Health in Jacksonville. This change ended some thirty-seven years of faithful service for Dr. Davis. He is to be congratulated on his fidelity to this important task across the years.

GRADUATE COURSES ANNOUNCED

The Committee on Medical Postgraduate Course announces the following courses to be presented under the auspices of the Medical Department of the Graduate School of the University of Florida with the cooperation of the Florida State Board of Health and the Florida Medical Association:

1. A three day seminar in Tuberculosis to be held at the State Sanitorium in Orlando, May 11, 12 and 13.

2. A special course in Cardiology to be held in Jacksonville, June 14 through June 17.

3. The Seventeenth Annual Short Course to be held in Jacksonville, June 27 through July 2.

Attention is also directed to the courses in Clinical Pathology planned by the Florida State Board of Health. These courses are of special interest to laboratory personnel, but are supported by the Medical Department of the Graduate School as part of the program of Graduate Medical Education. These courses are held in the evenings in various centers throughout the state, usually Miami, Tampa, Orlando, Jacksonville and Tallahassee. There will be a series of lectures on Serologic Interpretation by Dr. C. R. Rein during the week of February 20. To be announced in early March will be a series of lectures on Clinical Parasitology by Dr. Harold Brown, professor of Parasitology of Columbia University. In April, Dr. Norman F. Conant of Duke University will present a series of lectures on Recent Advances in

Mycology. The specific dates and places for these lectures will be announced shortly.

Programs and additional announcement of courses will be published soon. It is urged that all physicians make tentative plans to support these programs.

YOUR BLUE SHIELD

NO TIME FOR DEFEATISM

By the time this issue of the DCMA BULLETIN is out of the presses, results of the last National elections will almost be old news. But in the minds of us physicians, and of the dentists and all of those whose business is taking care of the health of the people, the results of the election will make it memorable for a long time to come.

We might as well come out candidly and state that for the hopes of all of us to remain free for a while longer, the date of November 2nd, 1948, is a very dark one. Of all the promises made in political campaigns, none was ever so frankly and clearly stated than that of Dewey against socialization of medicine. It is indeed too bad that he was not as clear and forthright in many other issues of general interest and was unable to get enough people to go out and vote for him and his party.

On the other hand, the party sent back to power by the undeniable majority of those who voted (not necessarily the actual majority of the people), the Democratic party, has gradually but openly developed during the last sixteen years into a socialist-laborite movement. And we know what the socialist-laborite party has done in England. . . .

Although we don't expect in this country ever to become the victims of a totalitarian form of government as those established elsewhere, it is becoming a distinct possibility that a very powerful state will gradually take over the individual liberties which have, for 172 years constituted the foundation of our freedom loving democracy.

Our people, not having lived for so long under monarchic rule, as those of Germany, Italy, Russia and its satellites, will not be as easily duped into accepting the yoke of absolute government control of everything in our lives. But under the guise of "giving something for nothing" in the well established routine, the advocates of a "planned economy" will now resume with renewed vigor their campaign to turn medicine in America into another pork barrel of political control and favoritism.

From control of medicine to control of the press, banking, public utilities, industry and all commerce, there is nothing but a little time and mountains of propaganda.

Shall we take it heads down and lead the sacrificial march to the altar of that modern god, the Omnipotent State?

Or shall we awake in time from our lethargy and become really organized and fight with our own weapons: our words to our friends and patients, our representatives and our newspaper, and our money to help carry on the fight?

The National Physicians Committee is carrying on a good fight for us but without the endorsement and the financial support of every one of us, the fight will be lost and we'll have to resign ourselves to become the employees of the state, mere cogs in the machines of socialist government.

Our best answer to the demand for wider and better distribution of medical care is in the Blue Cross-Blue Shield plans. These are growing well and in some states at least, are strong enough already to nullify the efforts of socialist propaganda.

But that is not enough. The pressure is too great and our plans must develop faster. We must heed Dr. Hawley's eloquent warning and forego our traditional conservatism and assume greater risks if necessary. To keep the development of the prepayment plans on a limited "research type" basis because of fear of overstepping actuarial calculations of risks is actually foolish in the face of the more imminent and dangerous one of losing the whole shebang to government control under pressure of powerful organized groups.

We must increase coverage and do it quickly in order to give the people what they demand—and will ultimately get anyway. Let's give it to them ourselves regardless of cost and degree of sacrifice, but let's save its control from the hands of the politicians.

Some few sections of organized medicine have come out in a very strong opposition to the plan of national unification of Blue Cross-Blue Shield Plans with objections which might have had some validity ten or fifteen years ago but which, in the present political and economic temper of the people, are outmoded, to say the least.

They fear centralization and state it would be control, and as bad as that of government. They forget that even if that centralization would place the control of the plans in a central office, the plans would still remain voluntary, there would be no general taxation to support an army of political appointees, and the doctors, not just politicians, would be in that controlling position.

Despite the avalanche of propaganda which has reached our desk in recent weeks, we can't help but feel that the advice of Dr. Hawley is wise and based on a just evaluation of facts. Any calm appraisal of the arguments on both sides will reach that conclusion.

It is said there are two sides to every argument. We find many a time that there is also an "in between." We have visualized the middle of the road in this case as a form of reciprocal arrangements between all the existing and future plans in a manner similar to that in which transportation companies operate throughout the country.

We have never heard of a railroad or an airlines dictator yet. But we have purchased a ticket in Miami for various parts of the country many times. We found ourselves traveling in the facilities of several different companies to reach our destination. We paid only once and had uniform service throughout with few minor variations.

Why would it be impossible to so standardize the prepayment plans that they could have mutual reciprocity with all others and allow national coverage at standard premium rates?

It is alleged that local plans must vary greatly because economic levels vary so much. We still can't see why they could not be adapted to the needs of national coverage. In this day and age of rapid transport, and superior facilities of communication, regional or sectional differences within the country are fading out much more quickly than some people realize. The myth of the "impoverished South" is fast becoming a matter of history, for its industrial growth is placing it on a par with many northern areas. Wages are as high here as elsewhere and so are living costs, health care not excluded.

Plans with national coverage could offer adequate and satisfactory health care insurance with hospitalization and all aspects of medical and surgical care at standard national premium rates which, as Dr. Hawley well suggested, could be of different levels for different economic groups. Additional "luxury" coverage in particular areas or for special groups might be arranged at extra premium fees, but the national setup is, we believe, the one and only way to give the kind of medical insurance demanded.

Again we say: Let's do it ourselves! Let's keep free! Let's keep the wolves (political-bureaucrats) away from the door of American medicine!

C. P. L.

Reprinted from
The Bulletin of the Dade County Medical Association
19:36-37 (*Dec.*) 1948

STATE NEWS ITEMS

At a recent meeting of the Gulf Coast Clinical Society which was held in Biloxi, Miss., Dr. Sidney G. Kennedy, Jr., was elected president, and Dr. Arthur J. Butt, Jr., was elected secretary-treasurer. Both are from Pensacola.

Dr. David R. Murphey, Jr., of Tampa was a guest speaker on the program of the Southern Surgical Association which met in White Sulphur Springs, W. Va., in early December.

Dr. W. Tracy Haverfield of Miami recently addressed members of the Psychology Club of the University of Miami. He spoke on prefrontal lobotomy. A motion picture on the technics of operation followed the lecture.

Dr. Shaler Richardson of Jacksonville and Dr. J. Brown Farrior of Tampa were guest lecturers at the Postgraduate Course in Ophthalmology and Otolaryngology of the University of Virginia which was held from November 30 to December 3. Dr. Richardson spoke on "Malignancies of the Iris" and "Office Management." Dr. Farrior spoke on "The Radical Mastoidectomy," "Ear Surgery in Facial Paralysis," "The Vertiginous Patient," and "The Fenestration Operation."

Following the 1949 meeting of the New Orleans Graduate Medical Assembly, March 7 through 10, a tour to Mexico has been arranged. The party will leave by Pan American Clipper on March 12 for Mexico City where a medical program will be held. The itinerary includes many other places of interest in Mexico. The group will return to New Orleans on March 27. For further information write the New Orleans Graduate Medical Assembly, Room 105, 1430 Tulane Avenue, New Orleans 12, La.

Fifteen members of the Florida Medical Association were registered at the annual meeting of the American Academy of Pediatrics which was held recently in Atlantic City, N. J. They are Drs. Warren W. Quillian and Hillard W. Willis, Tampa; Dr. A. Louis Girardin, Jr., Ft. Myers; Dr. Robert R. Harriss, Hollywood; Drs. Cornelia M. Carithers, Hugh A. Carithers and Nathan Weil, Jacksonville; Dr. James R. Boulware, Jr., Lakeland; Drs. Elias Freidus, George N. Leonard and Meyer B. Marks, Miami Beach; Dr. Alvyn W. White, Pensacola; Dr. Henry G. Morton, Sarasota; Drs. George L. Cook and Douglas D. Martin, Tampa.

Dr. Robert M. Sasso of Lake City has offices established at 219 East Duval Street for the general practice of medicine and cardiology.

Dr. William C. Blake of Tampa has returned to his practice after attending a course in Boston. The study covered newer developments in the diagnosis and treatment of cardiovascular diseases and was sponsored by the American College of Physicians. Dr. Blake is a member of the board of governors of the American College of Physicians.

Dr. C. Burling Roesch of Jacksonville announces the opening of his office at 1060 Riverside avenue. Dr. Roesch will limit his practice to general and thoracic surgery.

Drs. Robert B. McIver and Stewart Thompson were in Sarasota January 8 at the request of the Sarasota County Medical Society. Local hotels and other facilities were surveyed to ascertain if it would be possible to hold the 1950 annual meeting of the Association in Sarasota. A report will be made to the Board of Governors.

On Sunday, January 9, they met with the manager of the Belleview-Biltmore Hotel and two members of his staff to complete some details in connection with the annual meeting which will be held in April. In the afternoon a meeting was held in Tampa with the chairmen of local committees from the Hillsborough and Pinellas County Medical societies. These local committees are planning splendid entertainment for the doctors and their wives at Belleair during the Seventy-Fifth Annual Meeting of the Association.

SITUATION WANTED: On salary basis. Have Florida license. Ten years general practice. Protestant, married, three children. In forties; Tulane graduate. Postgraduate New York Polyclinic. Five years surgical service in 500 bed hospital. Wish to move to Florida. Give full details in first letter. Write 69-23, P. O. Box 1018, Jacksonville, Fla.

BIRTHS AND DEATHS

BIRTHS

Dr. and Mrs. Louis A. Wilensky, Jacksonville, announce the birth of a son on November 30.

Dr. and Mrs. Samuel R. Lamb, Jacksonville, announce the birth of a daughter on December 9.

DEATHS—MEMBERS

Dr. Lawrence Simcox, St. Petersburg	Oct. 3, 1948
Dr. Frank L. Keeler, Miami	Dec. 7, 1948
Dr. James E. Rawlings, Daytona Beach	Dec. 23, 1948
Dr. Noble A. Upchurch, Jacksonville	Dec. 31, 1948

DEATHS—OTHER DOCTORS

Dr. Thomas W. Rhodes, Ossining, N. Y.	Aug. 9, 1948
Dr. Clarence M. Trippe, West Palm Beach	Aug. 25, 1948

WANTED: Young doctor to be associated in office with established doctor; general practice including surgery. Central Florida community, 10,000 population; ample hospital facilities. Write 69-22, P. O. Box 1018, Jacksonville, Fla.

COMPONENT SOCIETY NOTES

ALACHUA

At a regular meeting on December 14, Dr. Alva T. Cobb, Jr., was installed as president of the Alachua County Medical Society by the retiring president, Dr. J. Maxey Dell, Jr. Dr. Stuart D. Scott is the new president-elect; Dr. James M. McClamroch has been elected vice president; and Dr. F. Emory Bell has been re-elected secretary-treasurer.

On December 10, members of the society and their wives were guests of the Bar Association of the Eighth Judicial Circuit of Florida at a dinner meeting. Warden Chapman of the state prison was the guest speaker. This is the second annual joint meeting of the two organizations. It is planned to continue the joint meetings each year.

BAY

The Bay County Medical Society at its annual election of officers on December 7 chose Dr. Martle F. Parker as president for 1949. Dr. Daniel M. Adams, Jr., was elected vice president, and Dr. Russell T. Stewart was re-elected secretary-treasurer.

BREVARD

At the regular meeting of the Brevard County Medical Society held on December 14, officers for the year 1949 were elected. They are Dr. Charles E. Russell of Cocoa, president; Dr. Arthur C. Tedford of Melbourne, vice president; Dr. Theodore J. Kaminski of Melbourne, who was re-elected secretary-treasurer; Dr. I. Kimbell Hicks of Melbourne, censor.

BROWARD

Officers of the Broward County Medical Society for the year 1949 are as follows: Dr. Paul G. Shell, president; Dr. Richard A. Mills, president-elect; Dr. Francis Haberman, vice president; Dr. Scottie J. Wilson, secretary; Dr. Samuel P. Nixon, treasurer.

COLUMBIA

At the regular meeting of the Columbia County Medical Society on December 3, officers were elected for the year 1949. Dr. Robert B. Harkness of Lake City was elected president, and Dr. Sybill Corbett of Jasper was elected vice president. Dr. Thomas H. Bates of Lake City was re-elected secretary-treasurer.

At the scientific session, Dr. Louie Limbaugh of Jacksonville and Dr. Malcolm J. Ford of the United States Public Health Service, Jacksonville, spoke on diabetes. Dr. Ford discussed in detail the operation of the case finding work that has been carried out in Duval County during the past year and a half.

Columbia County Medical Society is the first society of the Association to have its 1949 dues paid. Congratulations!

DADE

Officers of the Dade County Medical Association who will serve during the year 1949 include: Dr. John D. Milton, president; Dr. Donald W. Smith, president-elect; Dr. Jack Q. Cleveland, vice president; Dr. Benjamin G. Oren, who was re-elected secretary; and Dr. Ralph S. Sappenfield, who was re-elected treasurer.

DeSOTO-HARDEE-HIGHLANDS-CHARLOTTE-GLADES

The annual election of officers of the DeSoto-Hardee-Highlands-Charlotte-Glades County Medical Society was held on December 14 at Aqua Vitae Springs. Dr. John A. Simmons was elected president; Dr. Gordon H. McSwain, vice president; and Dr. Charles H. Kirkpatrick, secretary-treasurer.

The scientific program was presented by Dr. Leldon W. Martin of Sebring who discussed hernias.

DUVAL

Dr. Raymond R. Killinger is the newly-elected president of the Duval County Medical Society. The officers who will assist the president in 1949 include Dr. James L. Borland, president-elect; Dr. Charles F. Henley, vice president; Dr. Janet

G. Leser, secretary; Dr. A. Judson Graves, treasurer.

ESCAMBIA

Dr. Alvyn W. White is the newly-elected president of the Escambia County Medical Society. Other officers elected for the year 1949 are Dr. Alvin L. Stebbins, who was elected vice president, and Dr. Arthur J. Butt, Jr., who was elected secretary.

HILLSBOROUGH

Officers of the Hillsborough County Medical Association for the year 1949 were elected at the regular monthly meeting on December 7. Newly-elected officers are Dr. William M. Rowlett, president; Dr. David R. Murphey, Jr., president-elect; Dr. James L. Estes, vice president; Dr. Herschel G. Cole, who was re-elected secretary; and Dr. Thomas M. Edwards, treasurer.

INDIAN RIVER

The Indian River County Medical Society at its regular monthly meeting held an election of officers for the year 1949. Dr. John P. Gifford of Vero Beach was elected president, and Dr. Frank A. Sica of Fellsmere was elected vice president. Dr. William L. Fitts, 3rd, of Vero Beach was re-elected secretary-treasurer.

JACKSON

At the December meeting of the Jackson County Medical Society, officers for the year 1949 were elected. They are Dr. Daniel A. McKinnon, president; Dr. James T. Cook, vice president; and Dr. Francis M. Watson, who was re-elected secretary-treasurer.

On December 9, fifty-eight physicians and their wives, some from neighboring states, attended a meeting sponsored by the Jackson society. Guest speakers were Dr. J. Elliott Scarborough, director of Winship Clinic at the Emory University Hospital in Atlanta, who spoke on "Cancer of the Breast," and Dr. Conrad G. Collins, chairman of the department of gynecology at Tulane University School of Medicine, who spoke on "Cancer of the Vulva and Vagina." Dr. Walter C. Payne, president-elect of the Florida Medical Association, addressed the group on "Medical Public Relations."

LAKE

The officers who will serve the Lake County Medical Society for 1949 are: Dr. Leroy H. Oetjen of Leesburg, president; Dr. Glendy G. Sadler of Mt. Dora, vice president; and Dr. William L. Musser of Mt. Dora, secretary-treasurer.

LEE

At the regular meeting of the Lee County Medical Society on December 20, the following members were elected officers for the coming year: Dr. Curtis R. House, president; Dr. Angus D. Grace, vice president; and Dr. Joseph L. Selden, Jr., secretary-treasurer. The regular meeting date has been changed from the third Tuesday to the third Monday of each month.

MADISON-SUWANNEE

Dr. A. Franklin Harrison of Madison is the newly-elected president of the Madison-Suwannee County Medical Society. Dr. Irby H. Black of Live Oak was re-elected secretary for 1949, and Dr. John N. Sims of Live Oak was elected treasurer.

MANATEE

Newly-elected officers of the Manatee County Medical Society who will serve during 1949 include: Dr. Willis W. Harris of Bradenton, president, and Dr. Joseph A. Gibson of Palmetto, secretary-treasurer.

MARION

At the December 16 meeting of the Marion County Medical Society, which was held at the 1890 House in Ocala, officers for the year 1949 were elected. Dr. Robert E. Thompson of Ocala was elected president, and Dr. William H. Garvin, Jr., of Dunnellon was elected vice president. Dr. Bertrand F. Drake of Ocala was re-elected secretary-treasurer. Members present included Drs. William H. Anderson, Jr., Hugh H. Barfield, Richard C. Cumming, Bertrand F. Drake, William H. Garvin, Jr., Henry L. Harrell, Eaton G. Lindner, Carl S. Lytle, William J. McGovern, John N. Moore, Eugene G. Peek, Jr., and Ralph E. Russell. Dr. Charles H. Blandford, director of the Marion County Health Unit, and Dr. Lorenzo L. Parks of the Florida State Board of Health, Jacksonville, were guests.

MONROE

Dr. James B. Parramore was re-elected president of the Monroe County Medical Society for 1949. Dr. Allen S. Shepherd was elected vice president and Dr. Wallace H. Mitchell was elected secretary-treasurer.

At a recent meeting of the society, members met with the Naval medical officers of the local units in Key West. The speaker was Commander Rexel Goodman (MC) U. S. N., who spoke on "Some Aspects of Radiological Safety." A brief discussion of the paper was presented by Lieutenant Commander Richard Hanchett (MC) U. S. N. The former Key West Municipal Hospital is now under the ownership of Monroe County and is named the Monroe County Hospital.

ORANGE

At the regular monthly meeting of the Orange County Medical Society on December 15, the following officers were elected for the year 1949: Dr. Robert P. Henderson, president; Dr. Hollis C. Ingram, president-elect; Dr. Dorothy D. Brame, vice president; Dr. Gerald W. Jones, secretary; Dr. A. Fred Turner, Jr., treasurer; and Dr. Walton B. Wall, Jr., reporter.

PALM BEACH

At the annual election meeting on December 6 the following officers were elected by the membership of the Palm Beach County Medical Society: Dr. William E. Bippus of West Palm Beach, president; Dr. Ralph M. Overstreet, Jr., of West Palm Beach, vice president; Dr. Cecil M. Peek of West Palm Beach, secretary; Dr. Frederick K. Herpel of West Palm Beach, treasurer; Dr. Oscar L. Kelley of Palm Beach, reporter.

PASCO-HERNANDO-CITRUS

The annual election of officers of the Pasco-Hernando-Citrus County Medical Society was held on December 9 at the regular meeting held in the home of Dr. William H. Walters, Jr., of Lacoochee. The newly-elected officers are Dr. Donald G. Bradshaw of Zephyrhills, president; Dr. George R. Creekmore of Brooksville, vice president; Dr. William B. Moon of Crystal River, vice president; and Dr. W. Wardlaw Jones of Dade City, who was re-elected secretary-treasurer.

A general discussion of "Socialization of Medicine" was held. Members present included Drs. Donald G. Bradshaw, John T. Bradshaw, George R. Creekmore, S. Carnes Harvard, W. Wardlaw Jones, Jere W. Kirkpatrick, William G. Mason, William B. Moon and William H. Walters, Jr. Dr. Harold O. Brown and Dr. Ralph S. Torbett of Tampa were guests.

POLK

The annual election of officers of the Polk County Medical Society was held on December 8 in Lake Wales. Dr. Byron Y. Pennington of Lake Wales was elected to succeed Dr. Chester H. Murphy as president of the society. Dr. Emmett E. Martin of Haines City was elected vice president, and Dr. John W. Vaughn was re-elected secretary-treasurer.

PUTNAM

The Putnam County Medical Society held its annual election of officers at the December 14 meeting which was held at the Marion Hotel in Palatka. Dr. Grover C. Collins was elected president, and Dr. Lawrence G. Hebel was elected secretary-treasurer.

Dr. Walter G. Holloman of Jacksonville was the guest speaker at the scientific program. He discussed various skin diseases.

Members present included Drs. James W. Brantley, Grover C. Collins, James W. Davidson, Edward W. Ford, Lawrence G. Hebel, Bernard E. Kane and Claude M. Knight.

ST. JOHNS

The newly-elected officers of the St. Johns County Medical Society are as follows: Dr. Reddin Britt, president; Dr. Donald T. Rankin, vice president; Dr. S. Raymond Cafaro, who was re-elected secretary-treasurer; and Dr. Joseph A. Shelley, treasurer.

SARASOTA

Dr. Millard B. White of Sarasota is the newly-elected president of the Sarasota County Medical Society. Dr. Talmadge S. Thompson was re-elected secretary-treasurer.

SEMINOLE

The officers for the year 1949 of the Seminole County Medical Society were elected at the December meeting. Dr. Leonard I. Munson was elected president, and Dr. Charles L. Park was elected vice president. Dr. Frank L. Quillman was re-elected secretary-treasurer.

TAYLOR

The officers who will serve the Taylor County Medical Society during 1949 are: Dr. Walter J. Baker, re-elected president, and Dr. Ralph J. Greene, re-elected secretary-treasurer.

VOLUSIA

Members of the Volusia County Medical Society chose Dr. Joseph H. Rutter as president of the society for the year 1949. The annual election was held at the regular meeting in December. Dr. Eric H. Lenholt was elected vice president, and Dr. Robert L. Miller was re-elected secretary-treasurer.

The scientific program was presented by Dr. Hugh West of DeLand. He spoke on "Fractures of the Hip." Thirty-one members were present at the meeting.

WALTON-OKALOOSA

New officers of Walton-Okaloosa County Medical Society include Dr. Arthur G. Williams, Sr., president; Dr. Howard F. Currie, vice president; and Dr. Ralph B. Spires, secretary-treasurer. All members of the society have paid 1949 dues to the Association.

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INFLUENCING THE PRESENT TREND

There are many indications that 1949 is likely to be a crucial year for the medical profession. This may be the time when the decision has to be made by the American people whether they want to protect a system of medicine which has given the highest standards of health of any nation in the world, or whether they shall submit to a compulsory form which has proved a failure in every country in which it has been tried.

Just how serious the situation is and what the final results are to be remain to be determined. Whether doctors and their patients are to be allowed to retain their freedom depends largely upon the effectiveness of the public relations efforts of the doctors throughout the entire country. The issue will be settled, in a large measure, by the degree of medical public relations which has been developed, and is now being maintained in each local medical society and by each individual member of that society.

The Florida Medical Association noted the trend of public opinion several years ago and saw fit to institute a state level program of education in order to tell the profession's side of the story. This agency operates primarily today as a guiding and coordinating body for the basic medical public relations as carried on by the component societies. Public relations, medical or otherwise, is fundamentally a local proposition.

Several of the county medical societies now have active public relations programs. They are doing much to help ward off regimentation. In these sections there has been noticeable increase in the amount of medical news in the local newspapers. Editorial comment has taken on a more favorable aspect. There have even been some instances of a change from a highly critical attitude on the part of the editor of one questioning the wisdom of tampering with the health of the American people. It will pay to present the facts at every opportunity.

The Orange County Medical Society believes that the people who vote for Congressmen are not going to make their opinions felt unless they are given the true picture of what is in store for this country if government medicine becomes a reality. Its members are definitely taking the story to the people of the Orlando area.

They are sparking their local educational campaign with an aggressive speakers' bureau which is providing society members to talk before various clubs and civic organizations. In addition they have taken to the airways to reach many others through a series of radio programs on the several aspects of socialized medicine, and voluntary versus compulsory health insurance plans.

Local societies have also been doing an excellent job of contacting their Congressmen. This has been especially true, and particularly valuable, in the districts sending new Representatives to Washington. Now that the 81st Congress is in session, they need to be reminded again and again

(Continued on page 515)

BRONCHIAL ASTHMA



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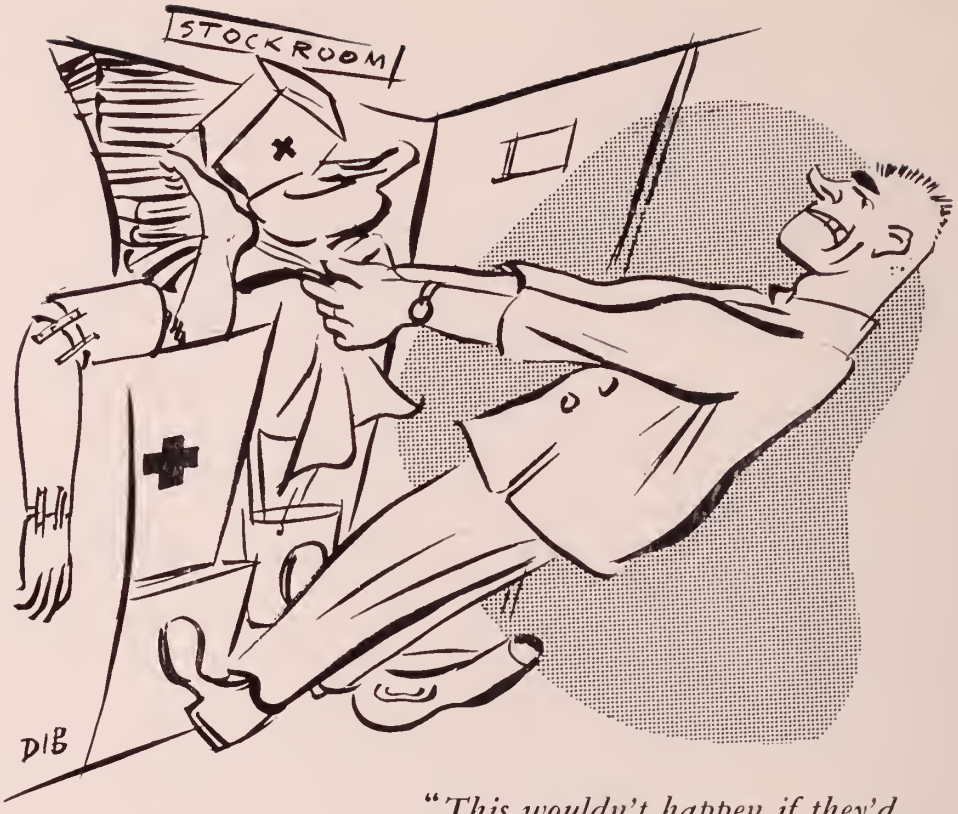
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SEARLE RESEARCH IN THE SERVICE OF MEDICINE

1. Mountain, G. E.: Bronchial Asthma, J. Iowa M. Soc. 35:324 (Aug.) 1945.



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that the people back home prefer to leave methods of healing to the physicians. Few Congressmen have been any more definite in their statements of opposition to socialized medicine, by whatever name it is called, than Congressman A. S. Herlong of Tavares.

LAWRENCE SIMCOX

Dr. Lawrence Simcox of St. Petersburg died on Oct. 3, 1948, enroute from Merrimac Point, Maine. He was 78 years of age.

Dr. Simcox was born in Houlton, Maine, on April 2, 1870. He attended preparatory schools in Presque Isle and Caribou in his native state and later was graduated from the Massachusetts College of Pharmacy. He received the degree of Doctor of Medicine from the University of Pennsylvania School of Medicine in 1897. Dr. Simcox became resident physician at St. Timothy's (now Memorial) Hospital in Roxborough, Philadelphia, following his graduation and practiced medicine in Philadelphia before moving to St. Petersburg and Gulfport.

He was a member of the Pinellas County Medical Society and the Florida Medical Association and was a fellow of the American Medical Association.

ARTHUR WELLESLEY WOOD

Dr. Arthur W. Wood of Miami died at his home on Nov. 21, 1948. He was 63 years of age.

Dr. Wood was graduated from the Atlanta School of Medicine in 1910. He located in Miami in 1925, moving there from Albany, Ga.

Prominent in religious and civic circles, Dr. Wood was vice chairman of the board of deacons of the Central Baptist Church and was a past president of the Miami Lion's Club. He recently was honored by this club for his work in the Lighthouse for the Blind, for his leadership in providing a children's home and in re-establishing the Community Chest, and for his assistance on other projects.

Dr. Wood was a member of the Dade County Medical Association, the Florida Medical Association, the American Medical Association and the Southern Medical Association.

Survivors include his wife, Mrs. Banks Wood; a son, Dr. Arthur W. Wood, Jr.; and a daughter, Mrs. Charles F. Sharp, all of Miami; three brothers, the Rev. Waldo E. Wood of Miami, Charles L. Wood of Harrison, Ga., and Thomas L. Wood of Winston-Salem, N. C.; and three grandchildren.

Advertisement



From where I sit
by Joe Marsh

To Dunk or Not To Dunk?

Dunking doughnuts is Sober Hopkins' favorite morning pastime . . . and for a long time now Ma Hopkins has been trying hard to break him of the habit. She feels it sets a bad example for the children.

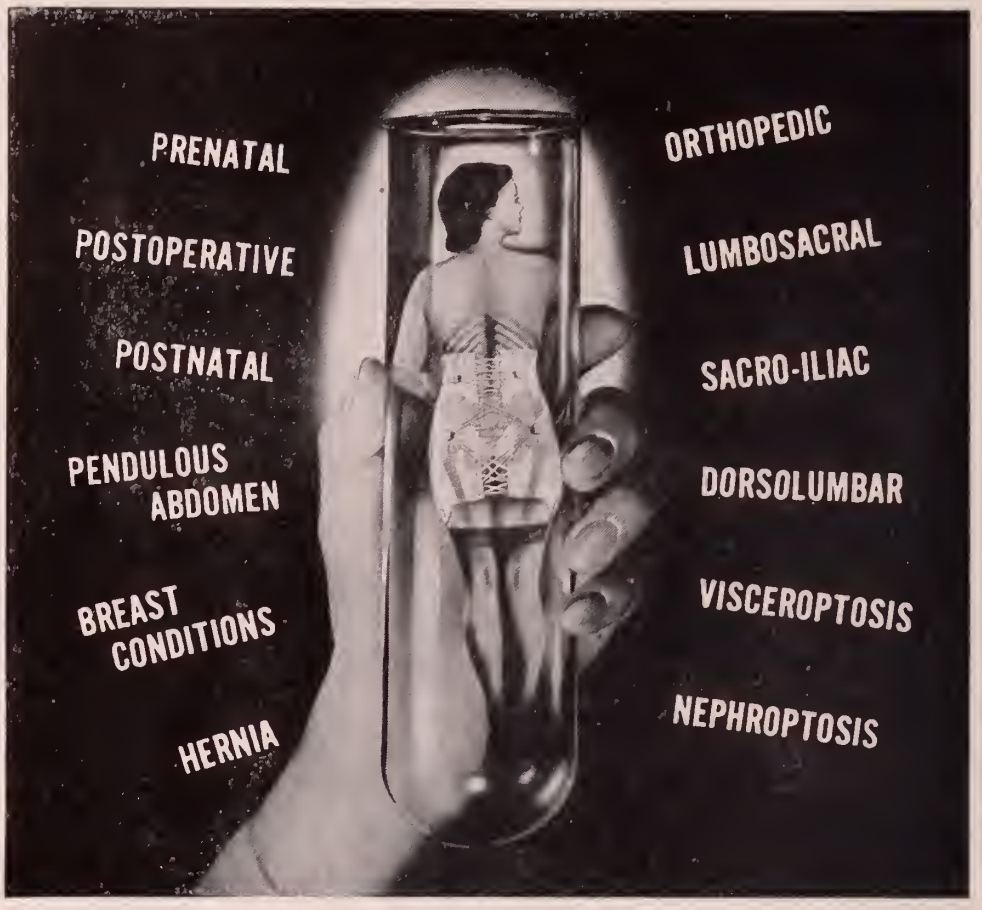
So one morning she puts a real heavy frosting of chocolate on the doughnuts . . . figuring that will surely stop him. Sober thinks it over for a little while and then: Dunk! Taste? Smile!! And Sober compliments the missus on the lovely mocha flavor!

I guess there'll always be two schools of thought: to dunk or not to dunk. But from where I sit, it's a matter of personal choice and taste—like some folks prefer beer to cider, ale to beer. And the less we criticize those differences of taste, the better.

In fact, Ma Hopkins got so curious about the flavor of chocolate-covered doughnuts dunked in coffee, that she tried it herself. Now—you've guessed it—she's a daily dunker, too!

Joe Marsh

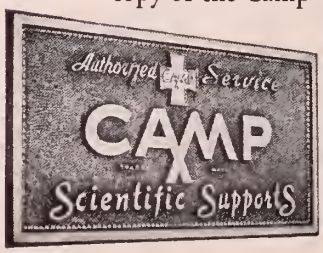
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LEONARD ALLEN BAKER

Dr. Leonard A. Baker of Miami died on Nov. 5, 1948, following a long illness. He was 66 years of age.

He was graduated from the University of Georgia School of Medicine in 1908 and practiced medicine in Tifton, Ga., his native state, before opening offices in Miami twenty-two years ago. He had been a staff physician at Jackson Memorial Hospital for several years and engaged in the practice of general surgery and pediatrics.

Dr. Baker was a member of the Dade County Medical Association, an honorary member of the Florida Medical Association, and a fellow of the American Medical Association.

Survivors include his widow, Mrs. Clyde M. Baker; a son, Leonard A. Baker, Jr.; and a daughter, Miss Lillian J. Baker, all of Miami; his mother, Mrs. J. J. Baker of Tifton, Ga.; and three sisters and four brothers.

BOOKS RECEIVED

MAKE YOUR MOVIES TALK. Pittsburgh, Pa.: The C. Lawrence Walsh and Company, 1948.

This booklet describes the method of preparing film for conversion from a silent to a sound film. Simplified footage scale charts, layout for the preparation of script and other important information are furnished.

ADVERTISER'S NOTES

Soon to be issued in book form are the Ciba illustrations of anatomy and pathology which have been prepared by Frank H. Netter, M.D. This new book will bring together portfolios of drawings which were distributed up to Jan. 1, 1948. The book will contain 224 pages, showing 191 of these anatomical charts printed in full color. It will be sold by Ciba at a price to cover only the actual printing and binding costs.

As a contribution to the crusade against cancer, the medical department of the G. D. Searle & Co. has prepared a booklet entitled, "Cancer, Visual Studies of Pathology and Diagnosis." This booklet is Volume 22 of the project, Research in the Service of Medicine. It is hoped that it may be of use to the physician in his efforts to curb the advance of malignancies.

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Dr. Charles A. Poindexter, New York
Medicine
Dr. Edward H. Rynearson, Rochester
Medicine
Dr. O. Spurgeon English, Philadelphia
Neuropsychiatry
Dr. Francis B. Carter, Durham
Obstetrics
Dr. Everett L. Goar, Houston
Ophthalmology
Dr. James S. Speed, Memphis
Orthopedic Surgery
Dr. C. Stewart Nash, Rochester
Otolaryngology
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Dr. A. Ashley Weech, Cincinnati
Pediatrics
Dr. Frederic E. Templeton, Seattle
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Surgical Technique, Surgical Anatomy & Clinical Surgery, Four Weeks, starting February 7, March 7.
Surgical Anatomy & Clinical Surgery, Two Weeks, starting February 21, March 21, April 18.
Surgery of Colon & Rectum, One Week, starting March 7, April 11.
Surgical Pathology, every two weeks.
GYNECOLOGY — Intensive Course, Two Weeks, starting February 21, March 21.
Vaginal Approach to Pelvic Surgery, One Week, starting February 14, April 4.
OBSTETRICS—Intensive Course, Two Weeks, starting March 7, April 4.
MEDICINE—Intensive Course, Two Weeks, starting April 4.
Personal Course in Gastroscopy, Two Weeks, starting March 7.
Electrocardiography, Four Weeks, starting March 16.
PEDIATRICS—Intensive Course, Two Weeks, starting April 4.
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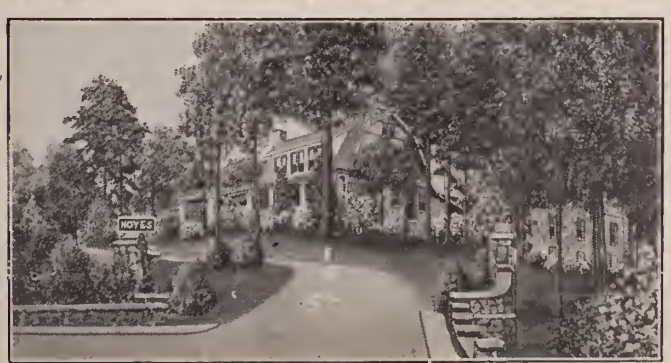
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SCHEDULE OF MEETINGS

ORGANIZATION	PRESIDENT	SECRETARY	ANNUAL MEETING
Florida Medical Association	Joseph S. Stewart, Miami	Robert B. McIver, Jacksonville	Belleair, Apr. 10-13, 1949
Florida Medical Districts	Herman Watson, Lakeland	Council Chairman	
A-Northwest	Irby H. Black, Live Oak	William P. Hixon, Pensacola	Quincy, 1949
B-Northeast	Rabun H. Williams, Eustis	Charles C. Grace, St. Augustine	Palatka, 1949
C-Southwest	John M. Butcher, Sarasota	H. Quillian Jones, Ft. Myers	Sebring, 1949
D-Southeast	Russell B. Carson, Ft. Lauderdale	Erasmus B. Hardee, Vero Beach	Ft. Lauderdale, 1949
Florida Specialty Societies			
Derm. and Syph., Soc. of	A. Buist Litterer, Miami	Wesley W. Wilson, Tampa	Belleair, April 10, 1949
Genl. Practice of Med.	M. Crego Smith, Clearwater	Walter E. Murphree, Gainesville	Belleair, April 10, 1949
Health Officers' Society	Roger F. Sondag, Jacksonville	Lorenzo L. Parks, Jacksonville	Belleair, April 10, 1949
Industrial & Railway Surgeons	F. Hardy Bowen, Jacksonville	J. H. Mitchell, Jacksonville	Belleair, April 10, 1949
Neurology & Psychiatry	James G. Lyerly, Jacksonville	William H. McCullagh, Jacksonville	Belleair, April 10, 1949
Ob. and Gynec. Society	Chas. J. Collins, Orlando	Dorothy D. Brame, Orlando	Belleair, April 10, 1949
Ophthal. & Otol., Soc. of	Bascom H. Palmer, Miami	W. Jerome Knauer, Jacksonville	Belleair, April 10, 1949
Orthopedic Society	Charles B. Mabry, Jacksonville	Eugene L. Jewett, Orlando	Belleair, April 10, 1949
Pathological Society	James N. Patterson, Tampa	Gretchen V. Squires, Pensacola	Belleair, April 10, 1949
Pediatric Association, State	Edgar W. Stephens, W. P. Beach	Hugh A. Carithers, Jacksonville	Belleair, April 10, 1949
Proctologic Society	Dean W. Hart, St. Petersburg	Frederick E. Farrer, Miami	Belleair, April 10, 1949
Radiological Society	James F. Pitman, Lake City	Floyd K. Hurt, Jacksonville	Belleair, April 9-10, 1949
Urological Society	Milton M. Coplan, Miami	Russell B. Carson, Ft. Lauderdale	Belleair, April 10, 1949
Florida—			
Academy, Public Medicine	Robert T. Spicer, Miami	Shaler Richardson, Jacksonville	Belleair, April 13, 1949
Basic Science Exam. Board	Paul A. Vestal, Winter Park	M. W. Emmel, D.V.M., Gainesville	Gainesville, June 11, '49
Dental Society, State	T. C. Henslee, D.D.S., Miami	Larry Schulstad, D.D.S., Bradenton	
Hospital Association	Mr. H. Louie Wilson, Gainesville	Mr. H. A. Schroder, Jacksonville	November, 1949
Hospital Service Corporation	Mr. W. E. Arnold, Jacksonville	Mr. H. A. Schroder, Jacksonville	Jacksonville, Feb., 1949
Medical Examining Board	Homer L. Pearson, Jr., Miami	Frank D. Gray, Orlando	Jacksonville, June 26-28, 1949
Medical Postgraduate Course	Turner Z. Cason, Jacksonville	Chairman	
Medical Service Corporation	Leigh F. Robinson, Ft. Lauderdale	Herbert E. White, St. Augustine	Belleair, April, 1949
Nurses Association, State	Mrs. Elsie M. Airheart, Tampa	Miss Helen Shearston, Miami	Sarasota, October, '49
Pharmaceutical Association, State	Mr. D. M. Weaver, Miami	Mr. R. Q. Richards, Ft. Myers	Miami, May 17-19, '49
Public Health Association	Turner E. Cato, Miami	Mr. Fred B. Ragland, Jacksonville	West Palm Beach, Oct. 6-8, '49
Tuberculosis & Health Assn.	Judge Ernest E. Mason, Pensacola	Mr. Walton MacJordan, Orlando	May, 1949
Woman's Auxiliary	Mrs. L. E. Parmley, Winter Haven	Mrs. C. R. Morgan, Jr., Miami	Belleair, Apr. 10-13, 1949
American Medical Association	R. L. Sensenich, South Bend. Ind.	Geo. F. Lull, Chicago	Atlantic City, June 6-10. 1949
Southern Medical Association	E. L. Henderson, Louisville, Ky.	C. P. Loranz, Birmingham	Cincinnati, Nov. 14-17, '49
Alabama Medical Association	J. Paul Jones, Camden, Ala.	Douglas L. Carnon, Montgomery	Montgomery, Ala., Apr. 19-21, 194
Georgia, Medical Assn. of	Edgar Hill Greene, Atlanta	Edgar D. Shanks, Atlanta	Savannah, Ga., May 10-13, '49
S. E. Hospital Conference	Mr. Burton M. Battle, New Orleans	Mr. R. F. Whitaker, Atlanta	Biloxi, Miss., April 27-29, '49
Southeastern Allergy Assn.	Clarence L. Laws, Atlanta	Kath. B. MacInnis, Columbia, S. C	
Southeastern, Am. College Phys.	Webster Merritt, Jacksonville	Florida Program Chairman	
Southeastern, Am. Urological Assn.	Harold P. McDonald, Atlanta	Russell B. Carson, Ft. Lauderdale	Boca Raton, March 21-24, '49
Southeastern Surgical Congress	Gilbert Douglas, Birmingham, Ala.	B. T. Beasley, Atlanta	

Every available means for checking has been used. Notification of errors or omissions should be mailed to P. O. Box 1018 (Fla. Theatre Bldg.). Jacksonville 1, for use in compiling the next Journal.

	SOCIETY	PRESIDENT	SECRETARY	MEETING DATE	MEMBERS Hon.	MEMBERS Regular	COUNCILOR
A	Bay	Martle F. Parker, M.D. Panama City	Russell T. Stewart, M.D. 224 East 4th St. Panama City		0	15	
	Escambia *Santa Rosa	Alvyn W. White, M.D. 24 W. Chase St. Pensacola	Arthur J. Butt, Jr., M.D. 1101 N. Palafox St. Pensacola	2nd Tuesday 8:00 P.M.	1	60	
	Franklin-Gulf	Albert L. Warl, M.D. Port St. Joe	Donald H. Anderson, M.D. Port St. Joe	3rd Tuesday Odd Months	0	6	A-1-50 William P. Hixon, M.D. Pensacola
	Jackson *Calhoun	Daniel A. McKinnon, M.D. Marianna	Francis M. Watson, M.D. 120 Deering St. Marianna	3rd Thursday 7:30 P.M.	0	15	
	Walton-Okaloosa	Arthur G. Williams, Sr. Lakewood	Ralph B. Spires, M.D. DeFuniak Springs	3rd Thursday 8:00 P.M.	0	13	
	Washington-Holmes	N. J. Dawkins, M.D. Vernon	B. W. Dalton, M.D. Chipley		0	5	
B	Columbia *Baker-Hamilton	Robert B. Harkness, M.D. 525 E. Duval St. Lake City	Thomas H. Bates, M.D. 27 W. Madison St. Lake City	1st Monday 7:30 P.M.	0	14	
	Leon-Gadsden-Liberty-Wakulla-Jefferson	Merritt R. Clements, M.D. 1232 N. Monroe Street Tallahassee	Edward C. Love, Jr., M.D. Masonic Temple Bldg. Quincy	Quarterly 7:30 P.M.	1	46	A-2-49 Irby H. Black, M.D. Live Oak
	Madison-Suwannee	N. Franklin Harrison, M.D. Madison	Irby H. Black, M.D. 918 W. Howard St. Live Oak		1	9	
	Taylor *Dixie-Lafayette	Walter J. Baker, M.D. Foley	Ralph J. Greene, M.D. Perry	Last Friday 8:00 P.M.	0	4	191
C	Alachua *Bradford, Gilchrist Union	Alva T. Cobb, Jr., M.D. 505 W. University Ave. Gainesville	F. Emory Bell, M.D. Box 400 Gainesville	2nd Tuesday 8:00 P.M.	1	34	
	Duval *Clay	Raymond R. Killinger, M.D. 450 St. James Bldg. Jacksonville	Janet G. Leser, M.D. 1016 LaSalle St. Jacksonville	1st Tuesday 8:15 P.M.	2	240	
	Marion *Levy	Robert E. Thompson, M.D. Holder Bldg. Ocala	Bertrand F. Drake, M.D. Professional Bldg. Ocala	3rd Wednesday 12:30 P.M.	2	27	B-3-50 Charles C. Grace, M.D. St. Augustine
	Nassau	David G. Humphreys, M.D. Fernandina	John W. McClane, M.D. Fernandina	Last Friday 8:00 P.M.	1	8	
	Putnam	Grover C. Collins, M.D. 502 Reid St. Palatka	Lawrence G. Hebel, M.D. 119 N. 4th St. Palatka	2nd Tuesday 6:00 P.M.	0	10	
	St. Johns	Reddin Britt, M.D. Box 565 St. Augustine	S. Raymond Cafaro, M.D. Exchange Bank Bldg. St. Augustine	3rd Tuesday 8:30 P.M.	1	14	
	Brevard	Charles E. Russell, M.D. 16 Magnolia St. Cocoa	Theodore J. Kaminski, M.D. Box 576 Melbourne	2nd Tuesday	0	14	
	Lake *Sumter	Leroy H. Oetjen, M.D. Leesburg	William L. Musser, M.D. Mount Dora	1st Wednesday 7:30 P.M.	1	23	B-4-49 Rabun H. Williams, M.D. Eustis
	Orange Osceola	Robert P. Henderson, M.D. 544 N. Orange Ave. Orlando	Gerald W. Jones, M.D. American Bldg. Orlando	3rd Wednesday 8:00 P.M.	4	130	
	Seminole	Leonard I. Munson, M.D. Touchton Bldg. Sanford	Frank L. Quillman, M.D. Box 158 Sanford	2nd Tuesday 5:30 P.M.	0	11	
	Volusia *Flagler	Joseph H. Rutter, M.D. Rt. 1, Box 503-A Daytona Beach	Robert L. Miller, M.D. 258½ S. Beach St. Daytona Beach	2nd Tuesday 7:30 P.M.	2	51	562
D	Hillsborough	William M. Rowlett, M.D. Box 786 Tampa	Herschel G. Cole, M.D. 315 Wallace S. Bldg. Tampa	1st Tuesday 8:00 P.M.	0	148	
	Manatee	Willis W. Harris, M.D. First National Bank Bldg. Bradenton	Joseph A. Gibson, M.D. Palmetto	3rd Tuesday 7:00 P.M.	0	18	C-5-49 John M. Butcher, M.D. Sarasota
	Pasco-Hernando-Citrus	Donald G. Bradshaw, M.D. Zephyrhills	W. Warulaw Jones, M.D. Box 247 Dade City	2nd Thursday 7:00 P.M.	0	14	
	Pinellas	Francis H. Langley 190 18th Ave. St. Petersburg	Whitman C. McConnell, M.D. 313 First Federal Bldg. St. Petersburg	1st Monday 6:30 P.M.	7	148	
	Sarasota	Millard B. White, M.D. 151 S. Pineapple Ave. Sarasota	Talmadge S. Thompson, M.D. Box 224 Venice	2nd Tuesday 8:30 P.M.	1	23	
	DeSoto-Hardee-Highlands-Charlotte-Glades	John A. Simmons, M.D. Box 430 Arcadia	Charles H. Kirkpatrick, M.D. Box 389 Arcadia	2nd Tuesday 8:00 P.M.	0	25	C-6-50 H. Quillian Jones, M.D. Ft. Myers
	Lee *Collier, Hendry	Curtis R. House, M.D. 2 Darling Bldg. Ft. Myers	Joseph L. Selden, Jr., M.D. 416 Richards Bldg. Ft. Myers	3rd Monday 7:30 P.M.	0	23	
	Polk	Byron Y. Pennington, M.D. Lake Wales	John W. Vaughn, M.D. Box 475 Lakeland	2nd Wednesday 7:00 P.M.	1	74	482
D	Indian River	John P. Gifford, M.D. Vero Beach	William L. Fitts, 3rd, M.D. Vero Beach Arcade Vero Beach	2nd Tuesday 8:00 P.M.	0	8	
	Palm Beach	William E. Bippus, M.D. Comeau Bldg. West Palm Beach	Cecil M. Peek, M.D. 535 S. Flagler Dr. West Palm Beach	3rd Monday 8:00 P.M.	1	92	D-7-50 Erasmus B. Hardee, M.D. Vero Beach
	St. Lucie-Okeechobee-Martin	Adrian M. Sample, M.D. Box 897 Ft. Pierce	Jerome A. Megna, M.D. 6th St. & Ga. Ave. Ft. Pierce	3rd Thursday 8:00 P.M.	0	13	
	Broward	Paul G. Shell, M.D. 420 Sweet Bldg. Ft. Lauderdale	Scottie J. Wilson, M.D. 309 Blount Bldg. Ft. Lauderdale	4th Tuesday 8:00 P.M.	4	61	D-8-49 Russell B. Carson, M.D. Ft. Lauderdale
	Dade	John D. Milton, M.D. 1105 Huntington Bldg. Miami	Benjamin G. Oren, M.D. 628 duPont Bldg. Miami	1st Tuesday 8:30 P.M.	6	483	
	Monroe	James B. Parramore, M.D. 523 Whitehead St. Key West	Wallace H. Mitchell, M.D. Key West	2nd Thursday 8:00 P.M.	0	13	681
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Vol. XXXV MARCH, 1949 No. 9

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Lamar L. Knight

Murine Typhus Fever
E. R. Rickard

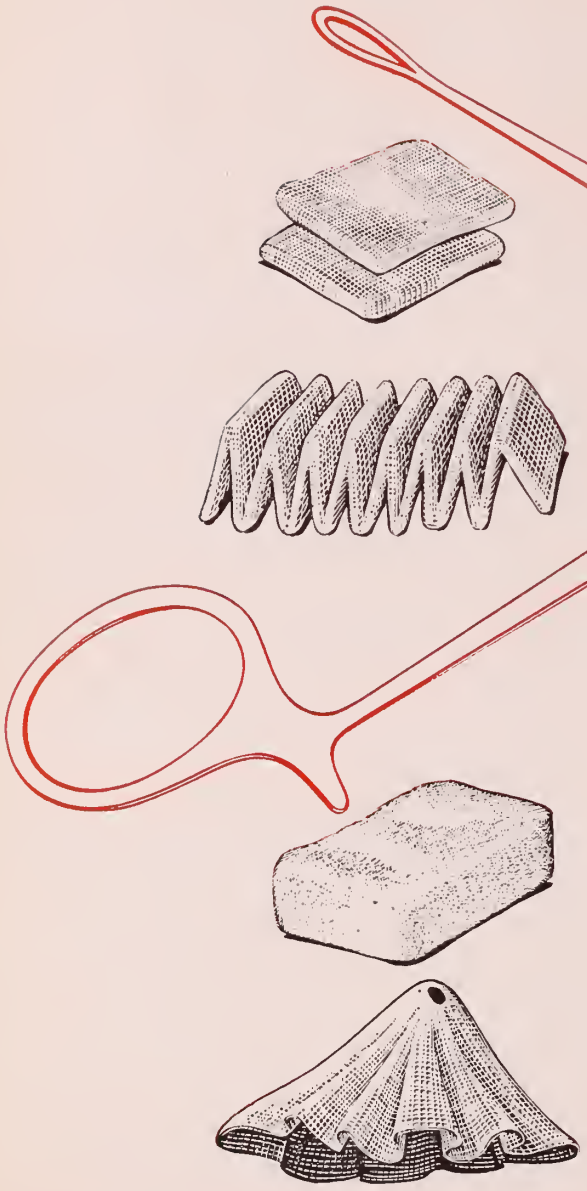
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The Physician's Approach to the Public
Editorials

Program of Annual Meeting, April 11-13

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This Journal is not responsible for the opinions and statements of its contributors.

Published monthly at Jacksonville, Florida. Price $5.00 a year; single numbers, 50 cents. Address Journal of the Florida Medical Association, P. O. Box 1018 (Fla. Theater Bldg.), Jacksonville 1, Fla. Telephone 6-1571. Accepted for mailing at special rate of postage provided for in Section 1103, Act of Congress of October 3, 1917; authorized October 16, 1918. Entered as second-class matter under Act of Congress of March 3, 1879, at the post office at Jacksonville, Florida, October 23, 1924.



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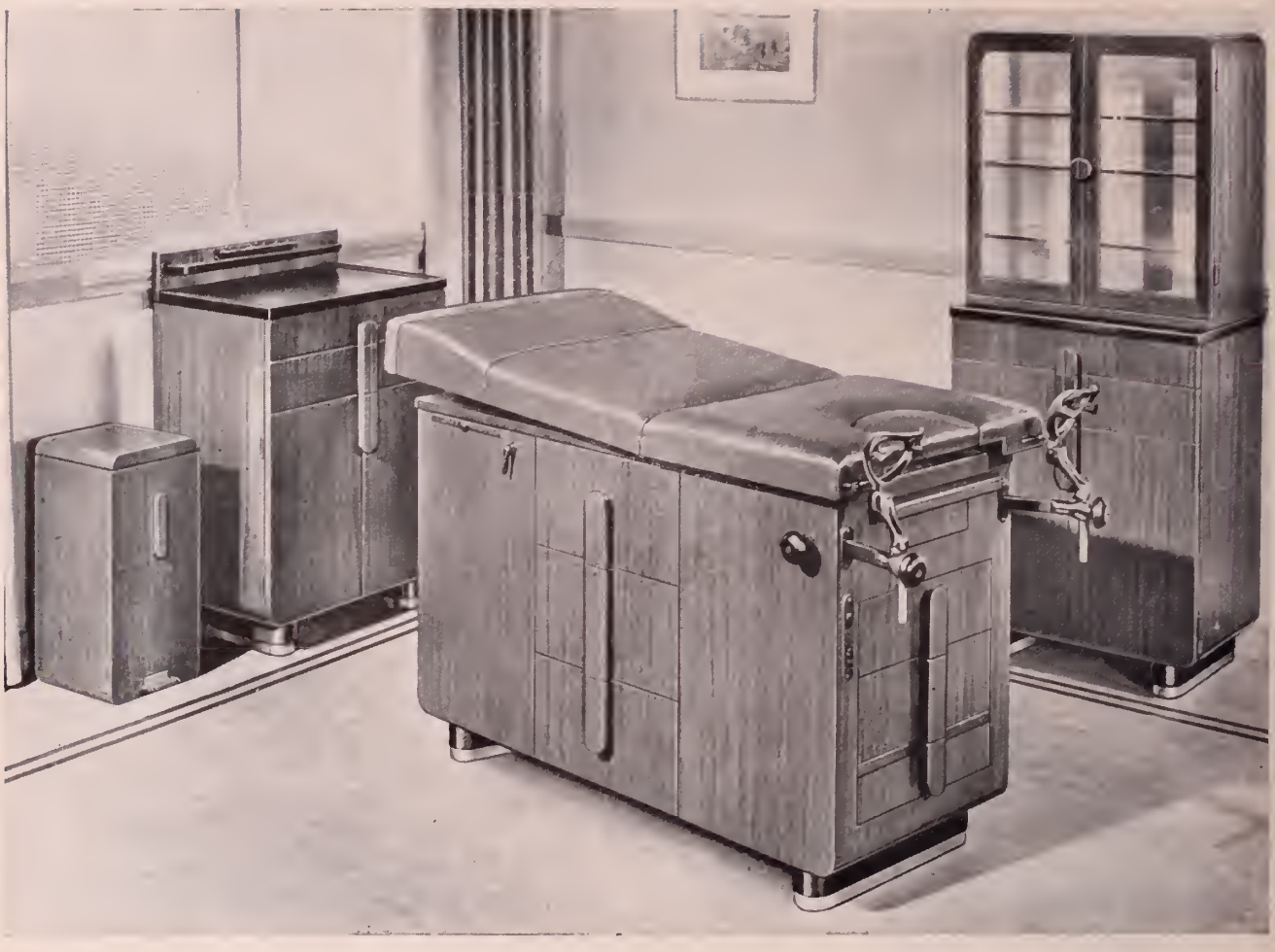
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1. Follis, R. H., Jackson, D., Eliot, M. M., and Park, E. A.: *Am. Jour. Dis. Child.*, 66:1, July, 1943.
2. Stearns, G.: *Jour. Lancet*, 63:344, Nov., 1943.



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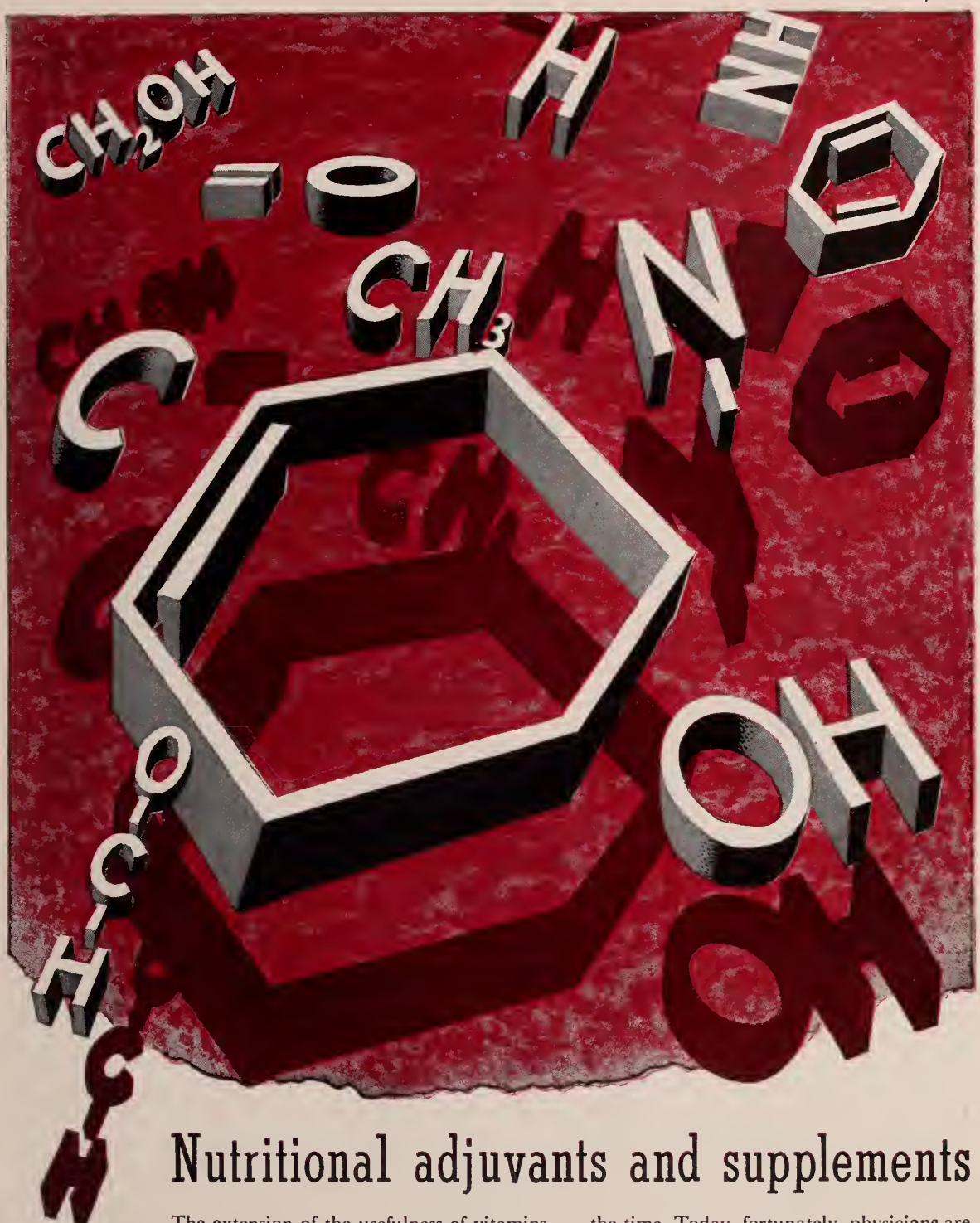
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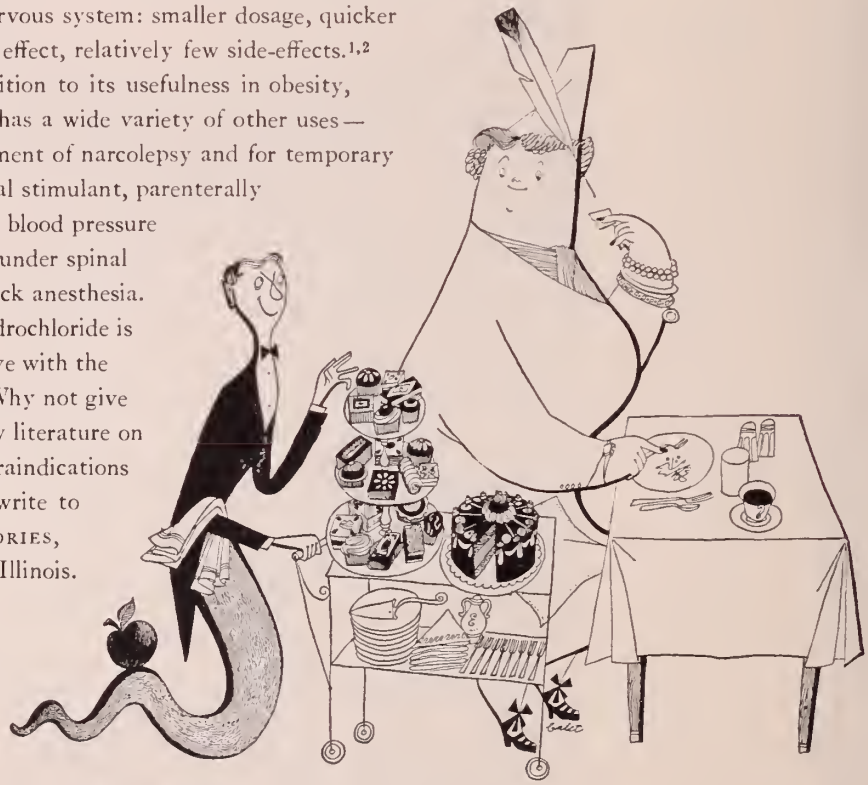


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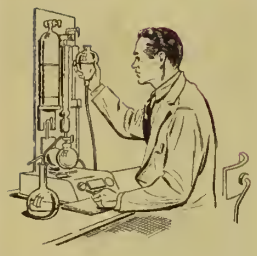
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THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION
PUBLISHED MONTHLY
Volume XXXV Jacksonville, Florida, March, 1949 No. 9

The Incidence and Diagnosis of Bronchogenic Carcinoma

LAMAR L. KNIGHT, M.D.
CLEARWATER

The incidence of primary pulmonary carcinoma of bronchial origin has shown a remarkable increase in recent years. Prior to 1910, only 2 per cent of all deaths from cancer were attributed to this type of tumor. Today, the statistics show that in from 12 to 15 per cent of all such cases coming to autopsy the disease is of bronchial origin.[1] Even more surprising are the figures showing that 8 per cent of all cancer is of this type. These statistics seemed unbelievably high until I considered that in a period of only one year there have occurred 4 proved and 1 strongly suspected case in the local relatively small 75 bed hospital.

What are the reasons for this great increase in the incidence of bronchogenic carcinoma? There are many theories, but none proved. Some believe the increases in the uses of tobacco, gasoline and other coal-tar products, particularly their widespread use in building highways, all may be factors producing increased bronchial irritation, to be followed by carcinoma.

Others think the increase is actually the result of improved diagnostic procedures, particularly the use of roentgen examination, bronchoscopy and more careful microscopic examinations of autopsy specimens. Boyd[2] concluded that in many cases formerly diagnosed at autopsy as abscess of the lung the condition was in reality bronchial carcinoma with suppuration and abscess formation distal to the obstruction, the tumor itself being missed in the mass of necrosed bronchial and pulmonary tissue. Even when found, the tumor was often called metastatic instead of primary.

The occurrence of bronchogenic carcinoma in relation to sex, age and race is interesting. An analysis[3] of 310 cases of proved primary bronchial carcinoma taken from the records of the Chevalier Jackson Clinic in Philadelphia showed that in 87 per cent of these cases the patients were men. It will be interesting to note during the next decade whether the increase in smoking among women will alter this surprising figure of male predominance.

Ages ranged from 20 to 80 years. Only 11 per cent of the patients in this series were below 40 years of age; 25 per cent were between 40 and 50; 44 per cent were between 50 and 60; and 22 per cent were between 60 and 80.

The white race shows about a 2 to 1 ratio of predominance over the Negro race.

DIAGNOSIS

In bronchogenic carcinoma the only diagnosis of any value is an early diagnosis. In this type of cancer, however, an early diagnosis is made more difficult by the simplicity and even occasional absence of early symptoms.

It is truly unfortunate that the commonest early manifestation should be a mild, nonproductive cough, a cough that the patient, and even the physician, should he consult one, might well shrug off as "too many cigarettes." Or, if the patient does not happen to smoke, it may be designated a "chest cold," a "chronic bronchitis" or some other such meaningless term.

Second in frequency among early symptoms is hemoptysis, which fortunately will usually arouse sufficient consternation in both the patient and physician to have further examination and study carried out.

Following cough and hemoptysis, wheezing is the next most frequent complaint. As this symptom may sometimes appear early, one must guard against labeling every chest that wheezes as asthmatic, especially if the wheeze should be localized or unilateral.

Dyspnea follows as the obstruction progresses. Atelectasis of obstructed pulmonary segments and compression by pleural fluid, if present, may also be factors in this complaint.

Pain is an indefinite symptom. It usually appears late in the history, but should the lesion originate peripherally with early pleural involvement, it may come earlier. Some patients may

Read before the Pinellas County Medical Society, May 6, 1948.

complain early of heavy, tender or dragging sensations in the chest. Such complaints are usually unfortunately passed off as some minor disorder of muscles or nerves.

In 89 per cent of the 310 cases analyzed there were early symptoms directly referable to the chest. In the remaining 11 per cent, the patients failed to complain of any symptoms originating in the chest until after obvious metastasis had occurred. Unfortunately, these patients must depend on chance roentgenograms of the chest or on mass industrial and civilian surveys of the chest for an early diagnosis.

Unexplained loss of weight must be considered a symptom. It sometimes occurs early and should not be considered as any indication of inoperability or metastasis, as suppuraton behind the obstructed bronchus may be the cause.

It is obvious that an early diagnosis of bronchial tumor by physical means alone is impossible. But the importance of recognizing certain physical findings in helping to reach an early diagnosis cannot be overemphasized. Certainly any abnormal finding in the chest, particularly one suggestive of a localized bronchial obstruction, or atelectasis, or the presence of pleural fluid should call for further examination and study.

ROENTGEN EXAMINATION

Naturally the first procedure to be considered must be a roentgen examination of the chest, including a preliminary fluoroscopic check. The abnormal findings in bronchogenic carcinoma most frequently demonstrated by roentgenograms of the chest are the result of some degree of bronchial obstruction. Atelectasis of a pulmonary segment blocked by the tumor is seen more frequently and often earlier than the shadow of the tumor mass itself.

A review of the roentgenograms of the chest in the 310 cases studied showed atelectasis was present in 58 per cent, while the tumor mass itself was demonstrated in only 44 per cent. Pleural fluid was seen in 18 per cent and obstructive emphysema in 3 per cent of the cases.

It is interesting to note that in 98 per cent of these cases some pathologic change within the chest was demonstrated by the roentgen examination alone; yet in the 2 per cent in which this examination gave essentially negative results, clinical observations were so suggestive that bronchoscopic examination and biopsy revealed the diagnosis.

Occasionally planigraphic roentgen studies and lipiodol bronchography may be helpful adjuncts to routine roentgen examination of the chest.

DIFFERENTIAL DIAGNOSIS

While a detailed discussion of differential diagnosis is not necessary, I think that a few of the diseases or lesions of the chest which most often confront and confuse one in making a diagnosis should be mentioned. They are bronchiectasis, pulmonary tuberculosis, abscess of the lung, pneumonia (particularly when resolution is delayed), pleural effusions from other causes, aortic aneurysm, atelectasis resulting from other forms of bronchial obstruction, bronchial asthma, metastatic tumors, advanced pneumokoniosis, lymphoblastoma, Hodgkin's disease, and Boeck's sarcoid. One must realize, too, that bronchial carcinoma may coexist with these or any other pathologic process in the chest.

BRONCHOSCOPY

As the majority of endobronchial tumors arise in the membrane of the larger bronchi, most lesions are accessible to bronchoscopic examination and biopsy. About 73 per cent of all bronchogenic tumors can be diagnosed by this procedure. Those lesions in the small segmental branches of the lower and upper lobes cannot be reached by the bronchoscope.

Bronchoscopy is a relatively simple and safe procedure with only a few contraindications. Certainly, any patient, with but few exceptions, having a chronic unexplained cough, hemoptysis or a localized wheeze, with or without abnormal roentgen findings, should be given the benefit of a bronchoscopic examination.

OTHER DIAGNOSTIC AIDS

Examination of the sputum for malignant cells is used successfully by some in the diagnosis of bronchial tumors. This technic is particularly popular in England, where some groups report up to 65 per cent positive diagnoses by this procedure alone. Great skill, patience and experience on the part of the pathologist is needed to make this method worth while.

Needle or aspiration biopsy of the tumor mass through the wall of the chest is occasionally used to reach otherwise inaccessible tumors. There is much dispute as to whether or not this procedure should be used. Some chest surgeons believe there is a definite possibility of transplanting tumor cells along the pathway of the needle.

Should pleural fluid be found, microscopic

study for the presence of tumor cells should be made. This procedure will sometimes give a definite diagnosis when other methods have failed.

Regardless of the methods used in attempting to make a positive diagnosis, there will be a few cases in which it is impossible to prove, yet disprove, the presence of bronchial cancer. Certainly in these cases, other factors favoring, the patient should be prepared for operation, and an exploratory thoracotomy carried out. Such a procedure, if done by a good chest surgeon, involves little risk and will definitely determine the presence or absence of a tumor, and, if present, whether or not surgical removal is feasible.

PATHOLOGY

Bronchogenic carcinomas are predominantly squamous cell in character, this type making up about 60 per cent of all the tumors diagnosed. Adenocarcinoma is next with mixed and undifferentiated cell carcinomas comprising most of the remainder.

Bronchial carcinoma invades the right lung almost twice as often as the left and the larger bronchi more frequently than the small.

OPERABILITY

The determination of the operability or inoperability in a proved or strongly suspected case of bronchogenic carcinoma is an extremely important and often difficult problem. While a detailed discussion is not in order, I consider it necessary to list a few factors that help decide whether or not a case is inoperable without resorting to exploration.

There are certain criteria or findings so definitely indicating the futility of operation that they are termed absolute evidence of inoperability. The first of these is, by physical examination, evidence of metastasis to lymph nodes or the thyroid gland, or actual invasion of the skin. These should of course be checked by biopsy. The second is, by roentgen examination, evidence of pulmonary metastasis, involvement of the esophagus, the destruction of ribs or vertebrae, or other metastases to bone. Third, bronchoscopic findings include gross involvement of the trachea, or involvement of the carina or proximal portion of the main bronchus. Fourth, the presence of bloody pleural fluid or the finding of tumor cells in a nonhemorrhagic pleural fluid definitely rules out any possibility of a successful operation.

TREATMENT

The only treatment of bronchial carcinoma, if the tumor is considered operable, is total removal of the lung involved.

The mortality for this operation when performed by good chest surgeons is now down to about 10 per cent. When one considers that the first successful pneumonectomy was done by Graham as recently as 1933, this is a remarkably low mortality figure.

In order best to illustrate the great importance of an early diagnosis in relation to the end result in this type of cancer, I present a summary of the operability of the 310 proved cases mentioned earlier. Of these, 240, or 71 per cent, were proved inoperable without exploration. In the remaining 80 cases, or 29 per cent, operation was recommended. In 9 of these cases it was refused, leaving 71 to come to operation. Of this number, in 41 the condition was found to be inoperable during the exploratory phase. Thus in only 30 cases, or 11 per cent of the original 310, was treatment by pneumonectomy successful.

More recent surveys have shown some improvement over this 11 per cent. In none, however, was the operability ratio better than about 1 out of 5.

Certainly these figures should be a challenge to all to realize the urgent necessity of an early diagnosis for the successful treatment of bronchogenic carcinoma.

SUMMARY

Bronchogenic carcinoma is a progressively common cancer, now causing about 15 per cent of all deaths from this disease and comprising 8 per cent of all diagnoses of cancer.

Its earliest manifestations in order of frequency of occurrence are chronic, nonproductive cough, hemoptysis, unilateral wheezing, dyspnea, pain in the chest and loss of weight.

The most useful methods in helping establish an early diagnosis are a careful history and examination of the chest, roentgen studies of the chest, bronchoscopic examinations and biopsy.

Bronchogenic carcinoma is curable by the early surgical removal of the entire lung involved.

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VOLUME XXXV
NUMBER 9

Murine Typhus Fever

E. R. RICKARD, M.D.
TAMPA

HISTORY

Epidemic typhus has been associated through the ages with wars, famines and disruptions of civilization. As the United States has never had a complete breakdown in its social or economic structure, the disease has not occurred here in epidemic proportions, although sporadic cases have been observed among immigrants, principally in the larger ports of entry.[1,2] Furthermore, as epidemic typhus is transmitted by the body louse, the high economic standards enjoyed by the greater portion of the population tend to make the spread of this disease unlikely. Until the beginning of the present century, typhus fever was seldom diagnosed in the United States. It is currently believed that such cases as were seen by physicians during the nineteenth century were misdiagnosed as typhoid fever.

In 1915 Brill,[3] a New York physician, described a series of cases observed chiefly among Russian immigrants in that city. He believed these cases to be typhus of the type that had been known to occur in European countries. For many years thereafter typhus fever occurring in the United States was called Brill's disease, and even today this term is often used.

In 1925 Maxcy[4] made a series of brilliant epidemiologic deductions based on observations in Montgomery, Ala., and in Savannah, Ga. He concluded that rats were the principal reservoir of typhus infection in the Southern United States. Later Dyer and others[5a,b,c] demonstrated that fleas were the principal vectors in the transmission of the infection from rat to rat and from rat to man. With this knowledge of the basic epidemiology of the disease, the term "murine typhus" was adopted to designate the typhus observed in the Southern states. This term is more accurately descriptive than "Brill's disease" because there is a possibility that the cases described by Brill were not flea-borne, but were the classical louse-borne European typhus.

During the past decade the number of cases of murine typhus reported in the United States has increased greatly, the increase being due in part perhaps to more certain clinical recognition of the disease. In 1944, 5,338 cases were reported to health departments. It is likely that this was a peak epidemiologic year, as the number of reported cases dropped to 5,167 in 1945 and, more markedly, to 3,367 in 1946. It is certain, however, that reported cases represent only a fraction of those which actually have occurred. In a recent statewide survey[6] of typhus in Florida, approximately two and one-half times as many cases as had been reported were found to have occurred over a three year interval. The survey showed that in the years 1944, 1945 and 1946 there had been in the state 1,234, 1,045 and 793 cases of human typhus, respectively. In 1947, 344 cases were reported to the State Board of Health. It is obvious that there has been a great epidemic recession of the disease. While part of this recession may be attributed to effective sanitation measures in certain areas, the downward trend has been noted in parts of the state where no such measures have been applied. It is possible, therefore, that in coming years a recrudescence of the disease will occur. In any case, murine typhus may be classified as an important major preventable disease in the Southern United States.

ETIOLOGY

The causative organism of murine typhus is the Rickettsia prowazeki mooseri, which was named in honor of Ricketts and Prowazeck, two early laboratory workers who died of typhus in the course of their investigations. Rickettsiae are small gram-negative rods barely visible with the oil immersion objective of the compound microscope. Like the filtrable viruses, they have not been found to grow on ordinary bacteriologic mediums, but have been cultivated only in the presence of living cells. The yolk sac of the developing chick embryo has been extensively and successfully employed for the cultivation of almost all rickettsiae. Diseases other than typhus caused by rickettsial agents which are known to occur in the United States are Rocky Mountain spotted fever, Q fever, and the recently described rickettsialpox.

The most important vector in the transmission of typhus from rat to rat and from rat to man is the tropical rat flea, Xenopsylla cheopis. Rats are commonly infested with other species of ectoparasites, almost all of which have been found capable

Field Staff Member, International Health Division, Rockefeller Foundation, assigned to the Florida State Board of Health.
Read before the Hillsborough County Medical Society, Jan. 6, 1948.

of transmitting infection; however, the consensus is that these play only a secondary role in the transmission of the disease. Following the ingestion of infected blood and an extrinsic incubation period, infected fleas pass large numbers of rickettsiae in their feces for the duration of their lives.[5d] Infection from the flea has been shown to occur when infected fecal material is rubbed into partially abraded skin in the act of scratching the flea bite.[5d]

Fleas have their greatest breeding activity in the hot humid months of the year. For this reason the peak incidence of human typhus cases is almost always observed in Florida during July or August; the lowest incidence occurs during the cool and relatively dry months of January, February and March. The recent statewide survey of the disease in Florida indicated that approximately 60 per cent of the cases were contracted in homes, principally those of poorer construction, and 35 per cent in business establishments. In 5 per cent of the cases the place of infection was not determinable.[6]

PATHOLOGY

The pathology of typhus fever is characterized by an endovasculitis with degeneration of the endothelial cells of the smaller blood vessels. In the rat, as well as in other small susceptible animals, typical typhus nodules are found in the brain, and sometimes in the spleen, of infected animals. These nodules resemble miliary tubercles both microscopically and macroscopically. Rickettsiae have been found to circulate in the blood of rats for periods up to thirty days following infection. In human beings rickettsiae may be isolated from blood during the febrile course of the disease. It seems possible that the organism may remain hidden in the internal organs of human beings for long periods of time. This hypothesis has been defended on epidemiologic evidence,[2] but has never conclusively been demonstrated by the actual isolation of the organism from a human being a long time after infection had occurred.

SYMPTOMS AND COURSE

The incubation period of murine typhus in man varies from one to three weeks; the usual duration is probably ten to twelve days. The onset may be gradual or abrupt and is accompanied by severe chills in about one half of the cases. The disease is characterized by severe constitutional symptoms and high fever, generally over 104 F. Severe headache, body pains and malaise are almost always present. In contrast to the apathy frequently observed in typhoid fever, the patient with typhus remains mentally alert and is generally apprehensive as well as fully aware of his discomfort.

A rash typical of the disease may appear on the third to the seventh day of illness. It is dusky macular or petechial in nature and is most commonly observed on the trunk of the body. In severe cases it may extend to the extremities and face. The rash may not be observed in all cases. Among several hundred persons in Florida with serologically confirmed cases of murine typhus, history of a rash was obtained from only about 60 per cent of those interrogated.[6] The presence of a rash is, therefore, a useful diagnostic sign, but its absence does not necessarily preclude the diagnosis of typhus.

The course of the disease varies greatly with the age and vigor of the patient. In the young and robust, fever generally ends by lysis in from ten to fourteen days, complications are rare and sequelae practically nonexistent. In older and previously debilitated patients, the disease may last for several weeks. In the elderly, pre-existing cardiovascular or renal diseases may be aggravated and sometimes lead to the death of the patient. The general mortality rate in murine typhus is about 3 per cent, but deaths nearly always occur among older persons. Mortality among the young is almost negligible.

LABORATORY FINDINGS

The white blood cell count in typhus is usually normal or slightly elevated or depressed. An appreciable leukocytosis generally suggests some complicating pyogenic infection. Aside from the serologic diagnosis to be discussed, there are generally no significant laboratory findings in this disease.

SEROLOGIC DIAGNOSIS

The Weil-Felix agglutination test has been used for many years in the diagnosis of rickettsial infections. It consists of the agglutination of Bacillus Proteus OX19 by the serum of the patient. A titer of 1:160 is ordinarily considered suggestive of infection, and one of 1:320 or more is regarded as diagnostic. In the recent statewide survey in Florida,[6] 1,337 patients who had had positive or doubtful reaction to the Weil-Felix test reported from state or private laboratories were investigated clinically by interrogation of attending physicians, the patients themselves or their families. Of this group of patients, 1,038 had serum titers of 1:320 or more. In 5 per cent of these 1,038 persons, however, the diagnosis of typhus was not considered clinically justified. Of a smaller group of 299

persons, among whom 1:160 was the maximum titer observed, 27 per cent were believed not to have had typhus. This percentage was considerably higher than in the previous group; nevertheless, 73 per cent of the 299 persons with titers of 1:160 were believed on clinical evidence to have had the disease, and in 44 per cent of these the diagnosis was confirmed by a typical typhus rash.

The Weil-Felix agglutination test does not differentiate epidemic typhus from murine typhus or either of these diseases from Rocky Mountain spotted fever. Epidemic typhus has not been known to occur in Florida. Rocky Mountain spotted fever, however, has been reported rather commonly in Georgia and Alabama and has been encountered in northwest Florida.[7] The Weil-Felix reaction is a relatively evanescent one. Maximum titers are generally reached on the fourteenth day of illness and gradually decline, until at about six weeks after the onset insignificant levels are reached. Previous typhus infection or vaccination against the disease, therefore, need cause no confusion in interpreting the test, as is often the case in interpreting the Widal reaction in typhoid fever.

The rickettsial agglutination test has also been used in the diagnosis of rickettsial diseases, but so far principally by experimental workers. Elevation and recession of titers observed in this test rather closely parallel those observed in the Weil-Felix test. As washed suspensions of the specific rickettsia are used as antigens, the test has the advantage over the Weil-Felix reaction of differentiating the various types of rickettsial diseases. Preparation of antigens involves much time-consuming and highly technical manipulation. They are therefore expensive if purchased commercially. This fact generally has precluded the use of the test as a routine diagnostic procedure.

The complement-fixation test for rickettsial diseases has been developed in recent years.[8a] The technic of this test is similar to that of the Wassermann or the Kolmer test for syphilis, except that purified rickettsial suspensions are used as antigens. The test has no inherent technical difficulties which would preclude its performance in the average well equipped and competently staffed clinical diagnostic laboratory. It also has the advantage over the Weil-Felix agglutination test of differentiating the various rickettsial diseases from one another. It is significant in relatively low titers.[8b]

Contrary to findings with the Weil-Felix and rickettsial agglutination tests, the serums of the majority of persons who have been affected with rickettsial diseases continue to fix complement with the specific antigen in relatively high titers for many years following infection. This occurrence may confuse the clinician interpreting the test, particularly in regions where murine typhus is highly endemic. In the presence of an acute illness, a positive complement-fixation test may have been caused by a previous undiagnosed typhus infection and may be coincidental to the current illness. Previous immunization with vaccines need cause no serious difficulty in the interpretation of the complement-fixation test as it does in the case of the Widal reaction. Although in a large proportion of persons receiving typhus vaccine there develop complement-fixing antibodies to the homologous antigen, in most cases these antibodies sink to nondetectable levels after a few weeks or months.[9a] Even at their peak, titers of complement-fixing antibodies produced by vaccines do not equal those generally produced by disease.

In spite of the foregoing limitations, the complement-fixation test in typhus fever has definite advantages for the clinical diagnostician. In certain persons a positive complement-fixation reaction may be obtained before the Weil-Felix reaction becomes significantly positive. Moreover, an increase in titer observed between specimens taken early and late in the disease definitely establishes the exact nature of the etiologic agent.

In addition to the serologic reactions discussed, there are the mouse neutralization test and the toxin neutralization test.[9b] These are mentioned only in passing as tests too complicated and time-consuming for the average clinical laboratory. They belong still to the realm of the research worker.

The diagnosis of typhus may also be established by isolating the rickettsiae from the blood of the patient during the acute phase of the disease and inoculating it intraperitoneally into guinea pigs, cotton rats and other small rodents. As such procedures require much time to obtain substantiated positive results, they are seldom useful to the clinician.

The most serious lack in the laboratory diagnosis of typhus is a reliable test to permit a positive diagnosis in the early pre-eruptive stage of the disease. With the present immunologic tests diagnosis is often delayed until the patient has almost recovered or until such a late date in illness that the clinician may be unable to give his patient the early benefit of such therapy as he believes indicated. Although no early diagnostic test has as yet been perfected in the rickettsial diseases, it is

encouraging to note that work aimed toward this end is being carried out in different research laboratories and that leads have been discovered.[10]

PROPHYLAXIS

The prevention of typhus may be considered from two points of view: environmental sanitation and the protection of the individual.

The extermination of rats or their ectoparasites in any community will protect the human population against murine typhus. It is true that in certain communities where rat extermination was promoted with great vigor a temporary increase in human typhus cases occurred because infected rat fleas left their dead natural hosts and attacked human beings.[11] Nevertheless, when rats are eradicated, typhus almost invariably disappears after a period of time.

There are many methods of fighting the spread of disease by rats. Probably the best is the proper construction or repair of buildings so that rats cannot gain entrance to them. Highly effective rat poisons such as antu and 1080 have recently been developed, and these have proved useful in anti-rat campaigns. But the cost of measures against rats is high, and for this reason the more practical method of controlling murine typhus is to attack the rats' typhus-transmitting fleas with the insecticide DDT. This substance has been used extensively by the United States Public Health Service in many Southern cities where typhus was highly endemic. When thoroughly and frequently scattered in a diluted form in the burrows, nests and runways of rats, DDT has been found to reduce the number of fleas on rats, and the number of typhus infected rats, as well as the number of human cases of typhus.

Vaccines against both murine and epidemic typhus are available commercially in the United States. Rickettsiae may be grown in large quantities in the yolk sac of the developing chick embryo.[12] This has permitted the use of killed rickettsial suspensions as preventive vaccines against most of the rickettsial diseases. In the case of European typhus, the value of such vaccines in the reduction of the severity of the disease has been demonstrated.[13] Although efficacy of vaccines in reducing the incidence of the disease still has not been proved, it is noteworthy that during the recent war all United States Army personnel were vaccinated and that the incidence of the disease among United States troops who were exposed was significantly lower than among the British troops, who were not vaccinated.

The value of vaccines in the prevention or the reduction of the severity of murine typhus has not as yet been demonstrated. It seems logical to assume, however, that if vaccines are of use against the European form of typhus, they may also be of benefit in the murine type. The rickettsiae causing the two diseases are closely related antigenically. Moreover, European typhus is more severe than is the murine type.

It should be noted that murine vaccine should be used only for the protection of persons who have been exposed to infection with murine strains of rickettsiae, such as neighbors of persons known to have typhus, or employees in business establishments where infection has occurred. Generalized vaccination of whole populations for the prevention of typhus does not seem to be indicated because of the expense of this method relative to the risk of infection.

Typhus vaccine is ordinarily given in three doses of 1 cc. each at weekly intervals. Reaction is generally mild or absent. When present, it usually consists of slight tenderness at the site of the injection lasting twenty-four to forty-eight hours. With the exception of persons who are sensitive to egg protein, there is no known risk. It is advisable, however, to question all patients as to their ability to eat eggs. If sensitivity is known or suspected, a preliminary sensitivity test by the intradermal injection of .05 cc. of the vaccine should be performed. Immune bodies in the serums of vaccinated persons reach their maximum titer about fifteen days after the completion of immunization. These bodies do not persist long; therefore, typhus vaccination should not be considered to confer immunity for a period of more than three months.

TREATMENT

Until recent years there has been no specific drug for the treatment of typhus. In 1942 the therapeutic effect of para-aminobenzoic acid on white mice experimentally infected with murine typhus was reported by Snyder and his co-workers.[14a] The inhibitory effect of this substance on the causative rickettsial agents of epidemic typhus, scrub typhus and Rocky Mountain spotted fever in the developing chick embryo was subsequently reported by other workers.[15a,b,16] Likewise, the beneficial effect of the drug in the treatment of human cases of these diseases has been recorded.[17,18,19] In a carefully controlled clinical experiment by Snyder and his co-workers in Cairo, Egypt, in 1945,[14b] the value of para-aminobenzoic acid in the reduction of the severity and the mortality of epidemic typhus was conclusively demonstrated. The bene-

ficial results obtained were particularly great when the administration of the drug was begun early in the course of the disease. The successful use of para-aminobenzoic acid in the treatment of human cases of murine typhus has also been reported in this country.

It would appear that the value of this drug in the treatment of rickettsial diseases is now so well established that no person with murine typhus should be denied its benefits. No serious toxic effects nor disagreeable side reactions have been reported. Certain patients may complain of nausea and vomiting due to gastric irritation, but such symptoms may nearly always be controlled by proper neutralization of the drug, or by the use of the sodium salt instead of the acid itself. As early administration of the drug is of great importance, it seems advisable, when typhus is suspected, to begin medication without waiting for a rash to appear. If the diagnosis is not substantiated either by the appearance of a rash or by positive serologic reaction, medication can be suspended.

Snyder and his associates[14b] recommended an initial oral dose of from 4 to 8 Gm. for adults, depending on the weight of the patient. As para-aminobenzoic acid is rapidly excreted in the urine, subsequent doses of from 1 to 3 Gm. every two hours throughout the day and night were recommended, in order to maintain a proper concentration in the blood. In the treatment of epidemic typhus, these authors recommended maintaining a blood level of 10 to 20 mg. of the drug per hundred cubic centimeters, determining the level each twenty-four hours. As murine typhus is generally less severe than the epidemic form, it seems unnecessary to exceed the blood levels recommended for the epidemic form.

Para-aminobenzoic acid is neutralized on administration by giving 20 cc. of a 5 per cent solution of sodium bicarbonate with each gram of the drug. The amount of sodium bicarbonate should be varied in order to maintain the neutral reaction of the urine. It is recommended that treatment be continued until the patient's temperature has returned to normal. Snyder and his associates[14b] reported a considerable lowering of the white blood cell count in almost all of a number of patients on para-aminobenzoic acid therapy. The temporary leukopenia resulted, however, in no harm in any instance, and the white blood cell count always returned to normal on cessation of therapy.

CONCLUSION

In conclusion it may be said that murine typhus, although at present in an apparent epidemic recession in Florida, is still an important preventable disease which may recrudesce in coming years. The disease may be controlled effectively by proper environmental sanitation. Although the application of such measures usually falls within the realm of public health departments, the private physician may be assisted in helping his patients by the recent development of more exact diagnostic tests, a promising preventive vaccine for those who are highly exposed, and a specific therapeutic agent of proved value in the treatment of the disease.

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Box 4298.

Tetanus: Report of a Case

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CLEARWATER
AND
Walter H. Winchester, M.D.
DUNEDIN

Recent war experience on the part of the armed forces of the United States demonstrated the effective protection afforded through antitetanus immunization. During the war years 1941 to 1945, only 12 cases of tetanus were reported by the Army, Navy and Marine Corps, while 488 cases were reported in the entire United States in 1947 alone. At the time of presenting this paper (Nov. 1, 1948) 43 cases had been reported in the state of Florida during the year. The following is a report of one of these cases:

REPORT OF CASE

Grace P., a 7 year old Negro girl, was first seen on the afternoon of Aug. 18, 1948, complaining of a sore throat and peculiar walking. Previous illnesses included measles, whooping cough and frequent attacks of tonsillitis. Her mother stated she had been immunized "like all the children in her family against typhoid, diphtheria and malaria." She became ill about two days previously, first noticing difficulty in swallowing, which she thought was a sore throat. Difficulty in walking consisted of falling backward, being awkward and clumsy. She complained of a slight frontal headache.

Physical examination showed a girl that did not appear sick. Her temperature, however, was 100 F. by mouth. The pulse rate was 120, and the rate of respiration was 20. The skin was normal in appearance, as were the eyes, ears and nose. She could not open her mouth more than ½ inch. Generalized tenderness was present on either side of the angle of the jaw with slight swelling suggesting tonsillar involvement. Examination otherwise gave negative results except for knock knee. The reflexes were normal.

The clinical picture changed dramatically in the next few hours. She remained alert and cooperative, though arched in moderate opisthotonos. Intermittently she had convulsive seizures produced by stimuli such as noise and light. She was immediately admitted to the hospital.

Treatment consisted of immediate sedation by the administration intravenously of 0.35 Gm. of sodium amytal, and the giving of 80,000 units of tetanus antitoxin (horse serum preparation) in 500 cc. of 5 per cent glucose in normal saline. Twenty-four hours later after additional intramuscular injections of luminal sodium, the temperature rose to 104 F. by rectum and the pulse rate to 140. Rectal administration of avertin was begun and continued at frequent intervals because of the frequent convulsive seizures; approximately 10.0 Gm. was administered in the first twenty-four hours. By the time the temperature had reached 104 F., the patient was placed in an oxygen tent; penicillin was given, 30,000 units intramuscularly every three hours, and in twenty-four hours increased to 50,000 units. All this time the patient was unable to take fluids by mouth, being much too drowsy to respond with more than an occasional cry for "mama." Fluids were therefore administered by rectum.

Consideration was given about this time to a search for a possible portal of entry. Numerous sores were found on both legs, which were possible lesions; on one heel a small scar marked the site where one week before onset of the symptoms the patient had stepped on a fishbone. A fragment of bone gradually extruded itself during the next two weeks. Surgical intervention was not attempted. The County Health Board by the fifth day of her illness had been able to determine that four small brothers and sisters of the patient had each been immunized with tetanus toxoid, but the patient had not.

On the fifth hospital day, the temperature was elevated to 107 F. by rectum, and Cheyne-Stokes respiration was present intermittently, with the pulse rate about 160 and respiration rate approximately 90. Sulfamerazine was begun by subcutaneous clysis. Physical examination at this time disclosed pneumonia in the upper lobe of the right lung, later confirmed by roentgenogram. Cooling enemas were given hourly for twenty-four hours, in addition to alcohol sponging. After twenty-four hours of sulfamerazine treatment dramatic improvement by crisis was noted, and the patient be-

Read before the Pinellas County Medical Society, Nov. 1, 1948.

came slightly responsive. At this point convulsions were infrequent; she was much too weak even to suck fluids through a straw, but she could swallow from a spoon and was started immediately on food by mouth beginning with ice cream. Amigen was administered intravenously, and attempts were made to rebuild nutrition.

Another complication appeared at this time, a pericardial friction rub; thoughts of endocarditis were entertained, but blood cultures were sterile. Antibiotics were stopped, the penicillin after 5,000,000 units and the sulfa drugs after 27 Gm. Since the hemoglobin dropped from 15 to 11 Gm., on September 9 a transfusion was administered of whole blood, previously carefully cross-matched. A severe reaction occurred beginning with a pronounced sense of constriction about the neck, followed by uncontrollable vomiting. Spiking temperatures followed for the next week.

Recovery proceeded rapidly after the transfusion reaction began to subside. The patient began gaining weight (she had lost 8 pounds) on a high calory, high protein diet with vitamin and iron supplements. After one week of normal temperature she left the hospital and has been followed weekly. She has continued to gain weight, and has resumed school. No residual defects mentally can be noted, and physically she is progressing well with only one exception, pyuria which is at present responding to treatment.

COMMENT

Various statistics have been given as to the mortality ranging from 20 to 80 per cent, the average being about 50 per cent. With a disease which has such serious prognosis, especially in those patients in whom the incubation period has been under ten days, we, as doctors, should endeavor to prevent rather than to rely wholly on curing tetanus after its appearance. Immunization by the use of toxoid is almost completely devoid of reactions, and circumvents the later use of horse serum. Tetanus develops in all varieties of wounds, including trivial-appearing superficial abrasions and scratches for which the average patient never consults a physician; or, should he be seen by one, would not have antitoxin administered.

SUMMARY

A case of tetanus with an incubation period of approximately seven days has been presented, in which complications developed including pneumonia, pericarditis and transfusion reaction, with subsequent recovery.

Tetanus is a preventable disease, as demonstrated by the war experience of the armed forces by means of mass immunization by tetanus toxoid, a measure which should be applied to the general population as far as possible.

ABSTRACTS OF MEDICAL ARTICLES

GRANULAR AREAS OF THE POSTERIOR URETHRA. By Lydia Allen DeVilbiss, M. D. Clin. Med. 54:303-304 (Sept.) 1947.

The painful urinary complaint of granular areas of the posterior urethra is described and its treatment discussed. A simple method of temporary home treatment consisting of an injection into the urethra of a healing substance in bland oil (cajandol which is 5 per cent oil of cajuput in peanut oil) is suggested. It is observed that a neurosis is the result and not the cause of the symptoms in some cases when this annoying condition is not infrequently resistant to treatment and recurs over a period of years.

A SIMPLIFIED CONSTANT PRESSURE IRRIGATOR. By A. Fred Turner, Jr., M.D., Louis M. Orr, M.D., and Joseph C. Hayward, M.D. J. Urol. 57:361-362 (Feb.) 1947.

A simplified device for maintenance of constant hydrostatic pressure in the resectoscope irrigating system is described and illustrated.

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Seventy-Fifth Annual Meeting

FLORIDA MEDICAL ASSOCIATION

Belleair

April 11, 12 and 13, 1949



Belleview-Biltmore
Headquarters Hotel

Recreational Facilities
Belleview-Biltmore Hotel









This is Belleair

The Hillsborough and Pinellas County Medical societies welcome the members of the Florida Medical Association to the Belleview-Biltmore Hotel at Belleair for the 1949 annual convention. Here there awaits you a spot of enchanting beauty difficult to excel. Located on the southern border of Clearwater, the Town of Belleair is a separate municipality, although it is a residential community except for a number of exclusive shops operated in connection with the hotel. The many beautiful estates surrounding the hotel are the homes of persons who appreciate the beauties of the area and who are steeped in Belleair tradition.

One of the many contributions of the Plant interests to the development of the central West Coast of Florida, the hotel was erected more than fifty years ago. For half a century it has been the mecca for a wealthy clientele seeking to escape the rigors of winter and bask in its comfortable and luxurious setting. Its size alone commands attention on first sight for it is one of the few places in the state where such a convention with all its exhibits can be housed under one roof. The excellent cuisine has been noteworthy ever since the hotel opened many years ago.

As large as it is, the hotel nestles in grounds almost unbelievable in scope and beautifully kept the year around. The golfer has merely to step outside to find at his disposal not one but two of the finest eighteen hole golf courses on the continent, whose fairways have been trod by the famed professionals and leading sportsmen of this country. Inside, the spacious halls have long been familiar to wealthy and cultivated leaders of business, literature and the arts. Here you may revel in an atmosphere that links the golden age of American development with the present. Among the hotel guests this season are some who were present at the original flag-raising ceremony.

Belleair and Clearwater are located on beautiful Clearwater Bay. This area comprises the highest coastal elevation on the Southeastern Atlantic and Gulf coasts of the United States. Nearby is located a small natural waterfall, a curiosity in Florida. Long before these communities attracted national attention, the United States Public Health Service designated this locality the most healthful spot in the nation. The Belleview-Biltmore was the attraction that started the population trek in this direction.

Clearwater, which has long since outstripped Belleair in size, is one of the most rapidly growing small cities in the state. It is linked by the beautiful Memorial Causeway to Clearwater Beach on the sparkling waters of the Gulf of Mexico. There you will find bathing beaches of shining white sand, some of Florida's finest restaurants and many other business establishments. Deep sea fishing boats are available at several piers. Many spacious homes dot the Beach, and on its northern end an exclusive Cabana colony fronts the Gulf. Both the Carlouel Yacht Club and the Clearwater Yacht Club are attractively situated on the island and each enjoys a large membership. Hotel and modern apartment units abound.

The county seat of Pinellas County, Clearwater is bounded on the north by Dunedin and on the south by Largo and Belleair. The city covers the width of the county to the east and from there is connected with Tampa by the famed Courtney Campbell Parkway across Tampa Bay. Driving over its many miles of paved streets, the visitor is impressed with its handsome city and county buildings, municipal auditorium, imposing churches and attractive homes. Clearwater and Belleair are the hub of the citrus industry of this area. In their environs and in the adjacent towns are located many processing plants.

At the Clearwater Country Club is located one of the better known Florida golf courses. In Dunedin, the Professional Golf Association of America owns and operates a Donald Ross course. Still another such course is located in Belleair near the hotel. The golfer may choose a different course each day.

For a great meeting in comfortable and inviting surroundings with unsurpassed recreational and scenic attractions, make your reservations early and come to Belleair.

PROGRAM

of the

Seventy-Fifth Annual Meeting

FLORIDA MEDICAL ASSOCIATION

To Be Held at BELLEAIR

APRIL 11, 12 and 13, 1949

REGISTRATION

The Registration Desk (*Main Dining Room Door Entrance*) will be open Sunday, Monday and Tuesday, 8:30 a.m. to 5:30 p.m., and Wednesday, 8:30 a.m. to 1:00 p.m. Every member will be required to register and obtain an identification badge before attending any of the sessions. Guests and ladies are required to register at the Main Registration Desk and obtain their badges.

There is no fee for registration. Printed programs will be on hand at the Registration Desk.

A fee of $3.00 will be charged for Smoker privileges at 9:00 p.m. Monday. Pay this fee at the Registration Desk and obtain your receipt tag which is to be shown at the door of the Clearwater City Auditorium and worn throughout the evening.

CONVENTION HEADQUARTERS

BELLEVIEW-BILTMORE HOTEL

The general headquarters will be the Belleview-Biltmore Hotel, where the registration desk, assembly room for general sessions, meeting place of the House of Delegates, scientific assemblies, information desk and technical exhibit hall will be located.

The Belleview-Biltmore Hotel will be headquarters for specialty groups Saturday and Sunday.

HOTELS

BELLEVIEW-BILTMORE—HOTEL HEADQUARTERS
(*American Plan*)

Single $15.00 Double $26.00

American Plan rates at the Belleview-Biltmore include meals, which are priced as follows:

Breakfast $2.00
Luncheon 3.00
Dinner 4.00

Since the Association does not underwrite tipping, it is suggested that each person tip at each meal on the basis of 10 per cent of the above amounts.

Persons not lodging at the headquarters hotel may be served in the Main Dining Room at the prices quoted.

OTHER HOTELS

CLEARWATER BEACH (*American Plan*)
(On Clearwater Beach)

Single Rooms	$ 8.00-9.00
Double Rooms	$16.00 up

SEA SHELL
(On Clearwater Beach)

Double Rooms	$10.00
Cottages (per week)	$30.00-45.00

CORONADO (*European Plan*)
(On Clearwater Beach)

Single Rooms	$ 5.00- 6.00
Double Rooms	$ 7.50- 9.50
Suite (four persons)	$15.00-16.00

WEST COAST

Single Rooms	$3.00
Double Rooms	$6.00

EAST SHORE APARTMENTS
(On Clearwater Beach)

Double Rooms	$ 5.00
Apartments (per week)	$35.00-60.00

GRAY MOSS INN

Single Rooms	$ 3.50- 5.00
Double Rooms	$ 4.00- 7.00
Two Adjoining Rooms (three persons)	$ 8.00-10.00
Two Adjoining Rooms (four persons)	$10.00-12.00

MOTELS

MOON
(Clearwater-Largo Road)

Double Rooms	$6.00-8.00

COLONY COURT

Double Rooms	$6.00-7.00
Rollaway Beds $2.00	

GULF BREEZE

Double Rooms	$6.00
Rooms (three persons)	$8.00
Rollaway Beds $2.00	

GOLF

The annual handicap golf tournament for members of the Florida Medical Association will be played at the Belleair Golf Links, adjoining the convention hotel. The tournament will be held Sunday, Monday and Tuesday, April 10, 11 and 12. Green fees will be $2.00 per day. The links will be available for members of the Association, Saturday, April 9, for practice rounds. Those wishing to participate in the tournament must be registered and show F. M. A. badges.

Rules: U. S. Golf Association, except local rules.

Handicaps: The local professionals will handicap the players. The entrant must register with the starter before beginning his tournament round.

Score card must be dated, signed, attested and turned in to the starter at the end of the round.

Voucher for prizes will be awarded at the Association dinner. First prize: Orlando Loving Cup (low net score). Many other attractive prizes will be awarded. The Belleair golf course is in excellent condition. (*The last winner of the Orlando Loving Cup, Dr. Robert D. Harris, Jr.,*

is requested to deliver the cup to Dr. Herbert B. Lott, chairman of the local committee, on his arrival at the convention.)

For any additional information communicate with Dr. Herbert B. Lott, 612 Citizens Building, Tampa, telephone M 2311.

WINNERS OF THE ORLANDO LOVING CUP

The Orlando Loving Cup was donated by the Orange County Medical Society at the Annual Meeting of the Florida Medical Association in 1931 at Orlando.

1931—M. A. Lischkoff, Pensacola
1932—Clarence A. Rudisill, Tampa
1933—Blackburn W. Lowry, Tampa
1934—Heyward J. Blackmon, Tampa
1935—M. A. Lischkoff, Pensacola
1936—Shaler Richardson, Jacksonville
1937—J. R. Chandler, Daytona Beach
1938—William Y. Sayad, West Palm Beach
1939—James T. Cowart, Tampa
1940—Lucien B. Dickerson, Clearwater
1941—William C. Roberts, Panama City
1942—Clarence A. Rudisill, Tampa
1943—No tournament (war)
1944—No tournament (war)
1945—No tournament (war)
1946—Walter C. Jones, Miami
1947—Walter F. Davey, Stuart
1948—Robert D. Harris, Jr., St. Augustine

ANGLERS

Deep sea fishing trips will be available. Boats leave from the City Pier and the docks at the beach end of the Causeway. Arrangements can be made for all day or short trips at nominal charges.

For additional information communicate with Dr. George C. Tillman, chairman of the Anglers Committee, 906 South Ft. Harrison, Clearwater.

ALUMNI AND FRATERNITY SUPPERS

Monday, 6:00 p.m.
Belleview-Biltmore Hotel—Main Dining Room

All persons wishing to attend an Alumni or Fraternity Supper are requested to notify Dr. C. Frank Chunn, local chairman, 442 West Lafayette Street, Tampa, telephone H 3602. It will be impossible to arrange for these suppers until word is received from all those who wish to attend. Please notify Dr. Chunn well in advance of the convention and specify which group you wish to attend. Each doctor planning to attend is requested to make a reservation at the information desk in the Main Lobby of the Belleview-Biltmore Hotel before 12:00 noon Monday.

ASSOCIATION DINNER

Tuesday, 7:00 p.m.
Belleview-Biltmore Hotel—Main Dining Room

Those who are not lodging at the headquarters hotel may obtain dinner tickets ($4.00 per person) from the hotel cashier.



Clearwater City Auditorium

SMOKER (*Not Stag*)

Monday, 9:00 p.m.
Clearwater City Auditorium

The social highlight of the convention will be the Smoker at the Clearwater City Auditorium, located at the entrance of the Clearwater Beach Causeway. A delightful evening of entertainment, including magic, dancing, novelty numbers and the awarding of a door prize, has been arranged for members, their guests and the ladies by the Smoker Committee, of which Dr. Everett M. Harrison is chairman.

A fee of $3.00 will be charged for Smoker privileges. Pay this fee at the Registration Desk at the Belleview-Biltmore Hotel and obtain your receipt tag which is to be shown at the door of the Clearwater City Auditorium and worn throughout the evening.

Arrangements for transportation by bus and/or taxi from the headquarters hotel to the auditorium have been made by the Transportation Committee, of which Dr. Raymond H. Center is chairman.

SCIENTIFIC EXHIBITS

The scientific exhibits will be located in the lobby of the headquarters hotel. We consider ourselves fortunate to be able to present for your approval the following exhibits:

1. Cancer of the Skin. Wesley W. Wilson, M.D., Tampa
2. Hazards of Sunshine to Human Skin. Chadbourne A. Andrews, M.D., and Morris Waisman, M.D., Tampa
3. Eye Surgery. Marion W. Hester, M.D., Lakeland
4. Services of the State Board of Health. Wilson T. Sowder, M.D., State Health Officer, Jacksonville
5. Some Practical Aspects of Radioisotope Therapy. J. Robert Andrews, M.D., Palm Beach
6. The Fenestration Operation. J. Brown Farrior, M.D., Tampa
7. Modern Concepts in the Treatment of Bronchiectasis. DeWitt C. Daughtry, M.D., Miami
8. Florida Medical Service (Blue Shield). Leigh F. Robinson, M.D., Ft. Lauderdale
9. Public Relations, Florida Medical Association. Frank G. Slaughter, M.D., Jacksonville

TECHNICAL EXHIBITS

Technical exhibits will be located in a section adjoining the Main Dining Room of the Belleview-Biltmore Hotel. The technical exhibits have a real scientific value, and physicians who wish to keep abreast of the times and be familiar with the latest development in drugs and medical appliances should spend some time with these exhibits; a surprising amount of useful information can be procured in this way. Many exhibitors have nothing to sell, the representatives of the firms being there to give the latest information regarding their products. Those who have items for sale will gladly give information whether there is a purchase or not. Be sure to register your name with the various representatives who are exhibiting.

The following firms have arranged for exhibits at the Belleair meeting:

A. S. Aloe Company
American Optical Company
Anderson Surgical Supply Company
Bilhuber-Knoll Corp.
The Borden Company
Byron Thompson & Company, Inc.
Camel Cigarettes
Cameron Surgical Specialty Company
Ciba Pharmaceutical Products, Inc.
The Coca-Cola Company
H. G. Fischer & Company
C. B. Fleet Company, Inc.
General Electric X-Ray Corp.
Keleket X-Ray of Florida
Lederle Laboratories
Eli Lilly and Company
J. B. Lippincott Company
M & R Dietetic Laboratories, Inc.
J. A. Majors Company
Mead Johnson & Company
The National Drug Company
Ortho Pharmaceutical Corp.
Parke, Davis & Company
Pet Milk Company
Philip Morris & Co., Ltd., Inc.
Picker X-Ray Corporation
Schering Corporation
G. D. Searle & Co.
Sharp & Dohme, Inc.
Shellmar Products Corp.
Spencer, Incorporated
E. R. Squibb & Sons
Surgical Equipment Company, Inc.
Tablerock Laboratories
R. H. Thomas
U. S. Vitamin Corp.
Walker Vitamin Products, Inc.
Winthrop-Stearns, Inc.

OFFICERS OF HILLSBOROUGH COUNTY MEDICAL SOCIETY

WILLIAM M. ROWLETT, *President*
DAVID R. MURPHEY, JR., *President-elect*
JAMES L. ESTES, *Vice President*
HERSCHEL G. COLE, *Secretary*
THOMAS M. EDWARDS, *Treasurer*

LOCAL COMMITTEES

CABINET

David R. Murphey, Jr., *Chairman*
Herbert B. Lott — Edward F. Shaver
James T. Cowart — C. Frank Chunn
Wesley W. Wilson — Chas. W. Bartlett

GOLF

Herbert B. Lott, *Chairman*
Joseph J. Ruskin — William G. Meriwether
John D. Flynn — V. LeRoy Hagan*

TRAPSHOOTING

James T. Cowart, *Chairman*
Joseph W. Taylor — John S. Helms, Jr.
Madison R. Pope — George C. Tillman*

PROJECTING LANTERN

Wesley W. Wilson, *Chairman*
Nathan L. Marcus — Manuel A. Perez
J. Maxwell Williams, Jr. — Everett M. Harrison*

LADIES' ADVISORY

Edward F. Shaver, *Chairman*
Harold G. Nix — Herschel G. Cole
Kenneth G. Gould — William M. Davis*

ALUMNI AND FRATERNITY SUPPERS

C. Frank Chunn, *Chairman*
Samuel G. Hibbs — Leffie M. Carlton, Jr.
Edward F. Carter, Jr. — Raymond H. Center*

FINANCE

Chas. W. Bartlett, *Chairman*
Edith M. Corlew — Linus W. Hewit
Clack D. Hopkins — Whitman C. McConnell*

**Advisory Members*

OFFICERS OF PINELLAS COUNTY MEDICAL SOCIETY

FRANCIS H. LANGLEY, *President*
ALBERT R. FREDERICK, *President-elect*
WHITMAN H. MCCONNELL, *First Vice President*
FRANKLIN W. ROUSCH, JR., *Second Vice President*
WHITMAN C. MCCONNELL, *Secretary-Treasurer*

LOCAL COMMITTEES

CABINET

M. Eldridge Black, *Chairman*
Everett M. Harrison — William M. Davis
George C. Tillman — Raymond H. Center
V. LeRoy Hagan — Whitman C. McConnell

SMOKER

Everett M. Harrison, *Chairman*
Julio J. Guerra — Percy H. Guinand
M. Crego Smith — Chas. W. Bartlett*

ANGLERS

George C. Tillman, *Chairman*
Robert M. Wolff — Francis H. Langley
Harold E. Winchester — Edward F. Shaver*

HOTELS AND RATES

V. LeRoy Hagan, *Chairman*
J. Sudler Hood — James H. Miller, Jr.
William R. Tench — C. Frank Chunn*

GREETERS

William M. Davis, *Chairman*
Albert R. Frederick — John D. Hagood
Wyatt H. Groves — Herbert B. Lott*

TRANSPORTATION

Raymond H. Center, *Chairman*
Lamar L. Knight — Walter H. Winchester
Thomas R. Purcell — Wesley W. Wilson*

FINANCE

Whitman C. McConnell, *Chairman*
John T. Bowen — Clyde O. Anderson
Virgil D. Smith — James T. Cowart*

**Advisory Members*

MONDAY

FIRST GENERAL SESSION

Monday, 9:00 to 9:15 a.m.

Belleview-Biltmore Hotel—The Starlight Room

Call to Order, Joseph S. Stewart, President
Invocation, The Reverend D. P. McGeachy, Jr., Th.D.
Address of Welcome, William M. Rowlett, President, Hillsborough County Medical Society, and Francis H. Langley, President, Pinellas County Medical Society
Announcements
Adjournment

SECOND GENERAL SESSION

Monday, 2:00 p.m.

Belleview-Biltmore Hotel—The Starlight Room

Call to Order, Joseph S. Stewart, President
Gavel to First Vice President, Herbert E. White
President's Address, Joseph S. Stewart
President Resumes Chair
Report of Secretary-Treasurer, Robert B. McIver, and Managing Director, Stewart G. Thompson
Report of Editor of The Journal, Shaler Richardson
Introduction, Delegates from other state societies
New Business
Announcements
Adjournment

SCIENTIFIC ASSEMBLIES

Committee on Scientific Work: Chas. J. Collins, Chairman, Orlando; Daniel A. McKinnon, Marianna; Frederick K. Herpel, West Palm Beach; Jere W. Annis, Lakeland; James L. Borland, Jacksonville.

Attention is called to the following By-Laws:

"All papers read before the Association shall be its property. Every paper shall be deposited with the secretary when read."

"No address or paper before the Association, except those of the president and orator, shall occupy more than fifteen minutes in its delivery, and no member shall speak longer than five minutes, or more than once on any one subject."

PROJECTORS

The Committee on Projecting Lantern, of which Dr. Wesley W. Wilson, Citizens Building, Tampa, is chairman, has arranged for a projecting lantern for use in The Starlight Room for the Association's Scientific Assemblies on Monday, Tuesday and Wednesday. An operator will be available at all times.

FIRST SCIENTIFIC ASSEMBLY

Monday, 9:15 a.m. to 12:15 p.m.

Belleview-Biltmore Hotel—The Starlight Room

9:15 a.m. "Early Ambulation of the Fused Low Back" (3¼"x 4" Slides), Royston Miller, Newton C. McCollough and Eugene L. Jewett, Orlando
9:45 a.m. "Pyuria, Differential Diagnosis; a Study of One Hundred Cases" (3¼"x 4" Slides), Frank J. Pyle, Orlando
10:15 a.m. "Hematuria; Its Clinical Significance" (3¼"x 4" Slides), Clarence G. Bandler, New York City
10:45 a.m. "Cancer of the Breast; a Comparison of Findings in a Charity and in a Private Hospital" (2"x 2" Slides), Edward Jelks and A. T. Kennedy, Jacksonville
11:15 a.m. "What May Be Expected from Irradiation Treatment of Nonmalignant Diseases" (3¼"x 4" Slides), Thomas H. Lipscomb, Jacksonville
Discussion: Aaron Z. Oberdorfer, Jacksonville

SECOND SCIENTIFIC ASSEMBLY

Monday, 3:30 to 5:30 p.m.

Belleview-Biltmore Hotel—The Starlight Room

3:30 p.m. "General Allergy in Children," Charlotte C. Maguire, Orlando
Discussion: Thomas C. Maguire, Plant City
4:00 p.m. "Early Closure of Burned Areas" (3¼"x 4" and 2"x 2" Slides), Michael L. Mason, Chicago
4:30 p.m. "Cancer of the Skin" (2"x 2" Slides), Wesley W. Wilson, Tampa
Discussion: Wiley M. Sams, Miami
5:00 p.m. "The Diagnosis and Treatment of Sterility" (2"x 2" Slides), Oren A. Ellingson, Tampa
Discussion: Edward V. Pollard, St. Petersburg

ALUMNI AND FRATERNITY SUPPERS

Monday, 6:00 p.m.

Belleview-Biltmore Hotel—Main Dining Room

SMOKER (*Not Stag*)

Monday, 9:00 p.m.

Clearwater City Auditorium

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Arrangements for transportation by bus and/or taxi from the headquarters hotel to the auditorium have been made by the Transportation Committee, of which Dr. Raymond H. Center is chairman.

TUESDAY

THIRD SCIENTIFIC ASSEMBLY

Tuesday, 9:00 to 11:25 a.m.

BELLEVIEW-BILTMORE HOTEL—THE STARLIGHT ROOM

9:00 a.m. "Diagnosis of the Commoner Hemorrhagic Diseases" (3¼"x 4" Slides), James N. Patterson, Tampa

9:30 a.m. "Heart Disease; a Clinical Evaluation" (3¼"x 4" Slides), Spencer A. Folsom and William H. Kelley, Orlando
Discussion: Webster Merritt, Jacksonville

10:00 a.m. "The Management of Eclamptogenic Toxemia" (3¼"x 4" Slides), Frederick H. Falls, Chicago

10:30 a.m. "Modern Concepts of the Prevention and Treatment of Puerperal Infection," Homer L. Pearson, Jr., Miami
Discussion: Cleland D. Cochrane, Daytona Beach

11:00 a.m. "The Circus," Joseph Halton, Sarasota

THIRD GENERAL SESSION

Tuesday, 11:30 a.m.

BELLEVIEW-BILTMORE HOTEL—THE STARLIGHT ROOM

Call to Order, Joseph S. Stewart, President

Address (by invitation), "Diagnosis of Cancer of the Breast" (3¼"x 4" Slides), Cushman D. Haagensen, Associate Professor of Clinical Surgery, Columbia University College of Physicians and Surgeons, New York

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FIRST MEETING HOUSE OF DELEGATES

Tuesday, 1:30 p.m.

BELLEVIEW-BILTMORE HOTEL—THE STARLIGHT ROOM

Delegates assemble at the Credentials Committee table at entrance of The Starlight Room at 1:30 p.m. to present their credentials, fill out attendance cards and receive special badges from the Credentials Committee,
Louis M. Orr, II, Chairman
Walter C. Payne
Herbert E. White

Delegates are to occupy seats in the section designated in order that they may be grouped together. Other members of the Association and guests are requested to occupy seats in another section of the room.

President Stewart in the Chair, 2:00 p.m.

Number of eligible Delegates present. Report by Louis M. Orr, II, Chairman, Credentials Committee

Motion to seat Delegates

Adoption of Minutes as published in June 1948 Journal

Report of Delegates to A. M. A. Meeting, November 1948: Homer L. Pearson, Jr., and Louis M. Orr, II

Election of one Delegate and one Alternate to A. M. A. House of Delegates for two-year terms

(A. M. A. By-Laws, Chapter I, Sec. 1: "A member of the House of Delegates must have been a member of the American Medical Association and a Fellow of the Scientific Assembly for at least two years next preceding the session of the House of Delegates at which he is to serve.")

Meeting Place, 1950 *(Recommendation of the Board of Governors)*

Reference Committee Personnel announced by President

Presentation of Resolutions *(Resolutions not included in House of Delegates Handbook and supplemental additions to annual reports of chairmen of committees should be typed in duplicate and placed on the speaker's table immediately after they are presented.)*

Reports of Committees:
Board of Governors, Duncan T. McEwan
Scientific Work, Chas. J. Collins
Legislation and Public Policy, W. Duncan Owens
Medical Education and Hospitals, Thomas C. Kenaston
Public Relations, Frank G. Slaughter
Necrology, Reddin Britt
Medical Postgraduate Course, Turner Z. Cason
Cancer Control, Alfred G. Levin
Medical Economics, John D. Milton
Venereal Disease Control, Jack A. McKenzie
Interrelationship, Henry J. Peavy
Tuberculosis and Public Health, Alvin L. Stebbins
State Controlled Medical Institutions, Lloyd J. Netto
Maternal Welfare, Harold G. Nix
Child Health, Warren W. Quillian
Conservation of Vision, Nathan S. Rubin
Advisory to Woman's Auxiliary, J. Lloyd Massey
Representatives to Industrial Council, Julius C. Davis
Council, Herman Watson

New Business

Announcements

Adjournment

FOURTH SCIENTIFIC ASSEMBLY

Tuesday, 3:30 to 6:00 p.m.

BELLEVIEW-BILTMORE HOTEL—THE STARLIGHT ROOM

3:30 p.m. "Pediatrics: Current Trends in Practice and Training" (3¼"x 4" Slides), Warren W. Quillian, Coral Gables
Discussion: George L. Cook, Tampa
Councill C. Rudolph, St. Petersburg

4:00 p.m. "The Master Two Step Exercise Test in the Diagnosis of Coronary Insufficiency" (3¼"x 4" Slides), Karl B. Hanson, Jacksonville
Discussion: William C. Blake, Tampa

4:30 p.m. "Urologic Consideration of Urinary Incontinence in the Female; Analysis of One Hundred and Twelve Cases" (3¼"x 4" Slides), Arthur J. Butt, Pensacola
Discussion: Robert B. McIver, Jacksonville

5:00 p.m. "Modified Authohemic Therapy Treatment," John A. Mease, Jr., Dunedin

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ASSOCIATION DINNER

Tuesday, 7:00 p.m.

BELLEVIEW-BILTMORE HOTEL—MAIN DINING ROOM

Those who are not lodging at the headquarters hotel may obtain dinner tickets ($4.00 per person) from the hotel cashier.

VOUCHERS FOR PRIZES

At Association Dinner
Golf and Other Sports Events

WEDNESDAY

BOARD OF PAST PRESIDENTS

Wednesday, 8:00 a.m.

Belleview-Biltmore Hotel—Main Dining Room

Breakfast

Election of Chairman, Vice Chairman and Secretary

FIFTH SCIENTIFIC ASSEMBLY

Wednesday, 9:00 to 10:30 a.m.

Belleview-Biltmore Hotel—The Starlight Room

9:00 a.m. "Streptomycin Therapy in Granuloma Inguinale" (3¼"x 4" Slides), Roger F. Sondag, Jacksonville
Discussion: Wesley W. Wilson, Tampa

9:30 a.m. "Comments on Diverticula of the Gastrointestinal Tract" (3¼"x 4" Slides), Gerard Raap, Miami

10:00 a.m. "The Management of Complications of Diabetes Mellitus" (3¼"x 4" Slides), Carlos P. Lamar, Miami

SECOND MEETING HOUSE OF DELEGATES

Wednesday, 10:00 a.m.

Belleview-Biltmore Hotel—The Starlight Room

Delegates sign official attendance cards at 10:00 a.m. at the table of Credentials Committee, Louis M. Orr, II, Chairman, Walter C. Payne and Herbert E. White, located at entrance of The Starlight Room. (*No Alternates are to be seated for Delegates attending yesterday's meeting*)

President Stewart in the Chair, 10:30 a.m.

Number of eligible Delegates present. Report by Louis M. Orr, II, Chairman, Credentials Committee

Recommendations of Reference Committees:

No. 1. Health and Education
Edward Jelks, Chairman

No. 2. Public Policy
H. Quillian Jones, Chairman

No. 3. Finance and Administration
Shaler Richardson, Chairman

Other unfinished Business

Election of Association Officers, 12:00 noon
President-elect
First Vice President
Second Vice President
Third Vice President
Secretary-Treasurer
Editor of The Journal

Dr. Walter C. Payne escorted to the Chair as new President

Presentation of Past President's Button and Certificate of Honor to Dr. Joseph S. Stewart by Dr. Walter C. Payne, President

Adjournment

SECOND ANNUAL MEETING

FLORIDA ACADEMY OF PUBLIC MEDICINE

(Public Relations for the Florida Medical Association)

Officers

Robert T. Spicer, President ..... Miami
Louis M. Orr, II, Vice President ..... Orlando
W. Duncan Owens, Vice President ..... Miami Beach
Shaler Richardson, Secy.-Treas. ..... Jacksonville

Wednesday, April 13

Belleview-Biltmore Hotel—The Starlight Room

2:00 p.m. Dr. Spicer presiding
Reading and approval of minutes of April 14, 1948 annual meeting
President's Report, Robert T. Spicer
Consideration of action of the House of Delegates on the Academy Board of Directors' unanimous vote to discontinue the Academy as an agency on public relations for the Florida Medical Association

SPECIALTY GROUP MEETINGS

Saturday and Sunday, April 9-10

On July 25, 1948 the Board of Governors ruled that rooms be assigned to the various specialty group societies on Sunday, as heretofore, but that the State Association is not to furnish projecting lanterns or any of the equipment necessary for the holding of such meetings.

Dr. Wesley W. Wilson, chairman of the local Committee on Projecting Lantern, advises that specialty groups may rent projection equipment, if desired, from the Southern Photo and News, 608 East Lafayette Street, Tampa 2.

SECOND ANNUAL MEETING

FLORIDA OBSTETRIC AND GYNECOLOGIC SOCIETY

Officers

Chas. J. Collins, President ..... Orlando
Robert G. Nelson, President-elect ..... Tampa
Dorothy D. Brame, Secy.-Treas. ..... Orlando

Sunday, April 10

Belleview-Biltmore Hotel—Villa Cottage

2:00 p.m. A meeting to adopt the Constitution and By-Laws of the Florida Obstetric and Gynecologic Society and to elect officers for the coming year will be held as indicated above. Any interested member of the Florida Medical Association is invited to attend this meeting.
Round Table Discussion, Frederick H. Falls, Chicago, Professor of Obstetrics and Gynecology, University of Illinois, Leader

7:00 p.m. Dinner, Main Dining Room—Wives and guests the members are invited to attend.

8:00 p.m. Scientific Session, Villa Cottage—"Ectopic Pregnancy" (by invitation), Frederick H. Falls, Chicago

FOURTH ANNUAL MEETING

FLORIDA HEALTH OFFICERS' SOCIETY

Officers

Roger F. Sondag, President ..... Jacksonville
Frank L. Quillman, Vice President ..... Sanford
Lorenzo L. Parks, Secy.-Treas. ..... Jacksonville

Sunday, April 10

Belleview-Biltmore Hotel—The Starlight Room

2:00 p.m. Scientific Session

1. "Diagnosis and Treatment of Diseases of Nutritional Origins," Walter Wilkins, Jacksonville
2. "Industrial Dermatitis." John M. McDonald, Jacksonville
3. "Premature Care," Edward L. Cole, Jr., St. Petersburg
4. "The Diagnosis and Early Treatment of Poliomyelitis" (by invitation), William F. Friedewald, Department of Bacteriology, Emory School of Medicine, Atlanta, Georgia

Business Meeting and Election of Officers

TENTH ANNUAL MEETING

FLORIDA SOCIETY OF OPHTHALMOLOGY AND OTOLARYNGOLOGY

OFFICERS

Bascom H. Palmer, President ..... Miami
Joseph W. Taylor, Vice President ..... Tampa
W. Jerome Knauer, Secy.-Treas. ..... Jacksonville

Sunday, April 10

BELLEVIEW-BILTMORE HOTEL—THE GRILL

2:00 p.m. Scientific Session
1. President's Address of Welcome, Bascom H. Palmer, Miami
2. "Benign Lesions of the Esophagus," Thomas M. Edwards, Tampa
Discussion: Joseph W. Taylor, Sr., Tampa
C. Frank Chunn, Tampa
3. "Corneal Section and Suture in Cataract Operation," Charles W. Boyd, Jacksonville
Discussion: Walton B. Wall, Jr., Orlando
Sherman B. Forbes, Tampa
4. Business Meeting
5. Annual Report of Florida Council for the Blind, Mr. M. Robert Barnett, Executive Secretary, Tampa

8:00 p.m. Scientific Session
1. "Retrolental Fibroplasia and Allied Conditions" (by invitation), Algernon B. Reese, New York
2. "Paralysis of the Larynx" (by invitation), Louis H. Clerf, Philadelphia
3. Election of Officers

ELEVENTH ANNUAL MEETING

FLORIDA STATE PEDIATRIC ASSOCIATION

OFFICERS

Edgar W. Stephens, Jr., President ..... West Palm Beach
Edgar E. Hitchcock, Vice President ..... Orlando
Hugh A. Carithers, Secy.-Treas. ..... Jacksonville

Sunday, April 10

BELLEVIEW-BILTMORE HOTEL—HIBISCUS COTTAGE

4:00 p.m. Case presentations
5:00 p.m. "A Review of Intestinal Parasitism in the Human," Part I, James L. Borland, Jacksonville
6:00 p.m. Business meeting
8:30 p.m. "A Review of Intestinal Parasitism in the Human," Part II, James L. Borland, Jacksonville

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REGULAR MEETING OF THE FLORIDA SOCIETY OF

DERMATOLOGY AND SYPHILOLOGY

OFFICERS

A. Burst Litterer, President ..... Miami
Giulio C. Bottari, Vice President ..... Tampa
Wesley W. Wilson, Secy.-Treas. ..... Tampa

Sunday, April 10

BELLEVIEW-BILTMORE HOTEL—MAIN DINING ROOM

6:30 p.m. Dinner
Round Table Discussion of Cases
Business Meeting
Election of Officers

THIRD ANNUAL MEETING

FLORIDA ORTHOPEDIC SOCIETY

OFFICERS

Charles B. Mabry, President ..... Jacksonville
Herbert W. Virgin, Jr., Vice President ..... Miami
Eugene L. Jewett, Secy.-Treas. ..... Orlando

Sunday, April 10

BELLEVIEW-BILTMORE HOTEL—ROOM NO. 29

3:00 p.m. Business Meeting
Election of Officers

SEVENTH ANNUAL MEETING

FLORIDA PATHOLOGICAL SOCIETY

OFFICERS

James N. Patterson, President ..... Tampa
Robert J. Poppiti, Vice President ..... Miami Beach
Gretchen V. Squires, Secy.-Treas. ..... Pensacola

Sunday, April 10

BELLEVIEW-BILTMORE HOTEL—BIGNONIA COTTAGE

2:00 p.m. General Business Session
Discussion of Pending Legislation
Technical Problems
Election of New Members
Election of Officers

8:00 p.m. Dinner—Main Dining Room

THIRD ANNUAL MEETING, FLORIDA

GENERAL PRACTICE OF MEDICINE SOCIETY

(In conjunction with Florida Chapter, American Academy of General Practice)

OFFICERS

M. Crego Smith, President ..... Clearwater
Gustav N. Click, Vice President ..... Pensacola
Walter E. Murphree, Secy.-Treas. ..... Gainesville

Sunday, April 10

BELLEVIEW-BILTMORE HOTEL—ALLAMANDA COTTAGE

2:00 p.m. "Program and Organization" (by invitation), Mr. Mac F. Cahal, Executive Secretary, American Academy of General Practice, St. Louis
"Human Side of Medicine" (by invitation), W. L. Pressly, Due West, S. C., General Practitioner of Year
Business Session and Election of Officers

TENTH ANNUAL MEETING

FLORIDA ASSOCIATION OF INDUSTRIAL AND RAILWAY SURGEONS

OFFICERS

F. Hardy Bowen, President ..... Jacksonville
Vernon A. Lockwood, President-elect ..... St. Augustine
Plumer J. Manson, Vice President ..... Miami
John H. Mitchell, Secy.-Treas. ..... Jacksonville

Sunday, April 10

BELLEVIEW-BILTMORE HOTEL—CASA MIA COTTAGE

4:00 p.m. President's Address
"Hand Surgery" (by invitation), Michael L. Mason, Chicago
Round Table Discussion
Business Meeting and Election of Officers

EIGHTEENTH ANNUAL SPRING MEETING

FLORIDA RADIOLOGICAL SOCIETY

OFFICERS

James F. Pitman, President ..... Lake City
John A. Beals, Vice President ..... Jacksonville
Floyd K. Hurt, Secy.-Treas. ..... Jacksonville

Saturday, April 9

BELLEVIEW-BILTMORE HOTEL—THE STARLIGHT ROOM

2:00 p.m. Round Table Discussions—Diagnosis
8:00 p.m. Round Table Discussions—Therapy

Sunday, April 10

BELLEVIEW-BILTMORE HOTEL—THE STARLIGHT ROOM

9:30 a.m. Business Session and Election of Officers

SECOND ANNUAL MEETING

FLORIDA UROLOGICAL SOCIETY

OFFICERS

Milton M. Coplan, President ..... Miami
A. Fred Turner, Jr., President-elect ..... Orlando
Russell B. Carson, Secy.-Treas. ..... Ft. Lauderdale

Sunday, April 10

BELLEVIEW-BILTMORE HOTEL—THE STARLIGHT ROOM

8:00 p.m. "Urologic Complications of Left Colon Sur-

gery" (by invitation), Clarence G. Bandler, New York City
Problem Case Clinic, Milton M. Coplan, Miami, Moderator
Business Meeting
Election of Officers

SECOND ANNUAL MEETING

FLORIDA **PROCTOLOGIC** SOCIETY

OFFICERS

Dean W. Hart, President ..... St. Petersburg
Frederick E. Farrer, Secy.-Treas. ..... Miami

Sunday, April 10

BELLEVIEW-BILTMORE HOTEL—ROOM NO. 11

3:00 p.m. Business Meeting
8:00 p.m. Scientific Session
1. "Lymphoblastomatosis of the Rectum," Thomas F. Nelson, Tampa
2. "Unknown Causes of Rectal Bleeding," Alexander E. Rosenberg, Miami Beach
3. "Errors and Complications in Proctologic Surgery" (by invitation), Thomas E. Smith, Dallas, Texas

THIRD ANNUAL MEETING, FLORIDA

NEUROLOGY AND **PSYCHIATRY** SOCIETY

OFFICERS

James G. Lyerly, President ..... Jacksonville
James L. Anderson, Vice President ..... Miami
William H. McCullagh, Secy.-Treas. ..... Jacksonville

Sunday, April 10

BELLEVIEW-BILTMORE HOTEL—ROOM NO. 9

4:00 p.m. Scientific Session
1. "Neurosurgical Relief of Intractable Pain," W. Tracy Haverfield, Miami
2. "Sodium Amytal in the Therapy of Neuropsychiatric Disorders," Samuel G. Hibbs, Tampa

Business Meeting and Election of Officers

ANNUAL MEETING

FLORIDA **MEDICAL SERVICE CORPORATION**

OFFICERS

Leigh F. Robinson, President ..... Ft. Lauderdale
Walter C. Jones, Vice President ..... Miami
Mother Loretta Mary, Vice President ..... Tampa
Frederick J. Waas, Treasurer ..... Jacksonville
John A. Beals, Asst. Treasurer ..... Jacksonville
Herbert E. White, Secretary ..... St. Augustine

Sunday, April 10

BELLEVIEW-BILTMORE HOTEL—SOUTHWEST CLUB ROOM

4:00 p.m. Dr. Robinson presiding

TWENTY-SECOND ANNUAL MEETING

WOMAN'S AUXILIARY

LOCAL COMMITTEE CHAIRMEN

HILLSBOROUGH

Mrs. Douglas D. Martin, *Chairman*

Mrs. Edward F. Shaver	Mrs. Harold G. Nix
Mrs. Leffie M. Carlton, Jr.	Mrs. William M. Rowlett
Mrs. Joshua C. Dickinson	Mrs. Joseph D. Scolaro
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The Registration Desk (*Main Dining Room Door Entrance*) will be open Sunday, Monday and Tuesday, 8:30 a.m. to 5:30 p.m., and Wednesday, 8:30 to 1:00 p.m. Auxiliary members and guests will be required to register and obtain their identification badges before attending any of the functions. Doctors' wives are invited to attend all activities of the Auxiliary.

There is no fee for registration. Printed programs will be on hand at the Registration Desk.

A fee of $3.00 will be charged for Smoker privileges at 9:00 p.m. Monday. Pay this fee at the Registration Desk and obtain your receipt tag which is to be shown at the door of the Clearwater City Auditorium and worn throughout the evening.

PROGRAM

Monday, April 11

Admission by F. M. A. Badge Only

9:30 a.m. Board Meeting, Belleview-Biltmore Hotel Southwest Club Room
12:30 p.m. Luncheon for Board Members, Main Dining Room
3:00 p.m. Tea for Auxiliary Members and Doctors' wives, The Grill
9:00 p.m. Smoker—Clearwater City Auditorium

Tuesday, April 12

BELLEVIEW-BILTMORE HOTEL—THE GRILL

9:30 a.m. General Auxiliary Session
Call to Order, Mrs. Lee E. Parmley, President
Invocation, The Reverend D. P. McGeachy, Jr., Th.D.
Pledge of Auxiliary, Mrs. Reaves A. Wilson, Sarasota
Address of Welcome, Mrs. Kenneth G. Gould, Tampa, and Mrs. Paul L. White, St. Petersburg
Response, Mrs. Cleland D. Cochrane, Daytona Beach
In Memoriam, Mrs. Chester H. Murphy, Bartow
Introduction of Guests
Reading of Minutes, St. Augustine Convention, Mrs. C. Russell Morgan, Jr., Miami
Roll Call
Convention Rules of Order, Mrs. Kenneth E. Montgomery, West Palm Beach
Credentials and Registration, Mrs. Douglas D. Martin, Tampa
Reports:
Officers and Chairmen
County Presidents
President's Message, Mrs. Lee E. Parmley, Winter Haven
Election of Delegates to National Convention
Report of Nominating Committee, Mrs. Clarence D. Rollins, Jacksonville
Election of Officers
Installation of Officers, Mrs. Gordon H. Ira, Jacksonville
Inaugural Address, Mrs. Charles F. Henley, Jacksonville
Address, Dr. Walter C. Payne, Pensacola
Courtesy Resolutions, Mrs. Richard F. Stover, Miami
Announcements
Adjournment
1:00 p.m. Luncheon—Main Dining Room
7:00 p.m. Association Dinner—Main Dining Room

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From Our President

ECONOMIC LEADERSHIP IN MEDICINE

American Medicine had best take heed of the widespread interest among the citizens of this country in the problems of medical care, compulsory health insurance and socialized medicine. The subject is being discussed throughout the country. It is being discussed by people who know something about it and by millions who are completely in the dark as to its implications. It is being discussed by propagandists, pro and con, in magazine articles and in newspapers, by radio commentators and radio comedians. Honest citizens by the millions, perplexed citizens, and citizens angered by unfortunate experiences involving the high cost of medical care are discussing it.

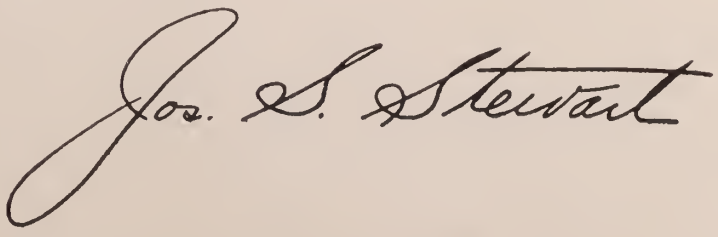
The leaders of those who believe in the political philosophy of socialization are a well organized group led by Mr. Oscar Ewing, Chairman of the Federal Security Administration. It is best that we take cognizance of the fact that Mr. Ewing is a brilliant leader, that his campaign is well organized and that it is financed by the resources of the United States Treasury.

It is the duty of American Medicine to take the leadership in any discussion involving the health of the people. But American Medicine has not taken leadership in the widespread discussions of today. We have condoned the leadership of the Fishbein era, which has consisted of the holier than thou attitude, of standpattism and platitudes. We have been against and never for. Our offensive line has never taken the field, but, relegated to the bench, it has watched with growing interest the plight of the defensive line as it has been ripped to pieces, worn out and run over.

We, the doctors, have been satisfied to bask in the glories of our heritage and of our scientific achievements, glories which our most severe critics recognize and applaud. We have devoted our efforts to the cure of our patients with little constructive thought on the matter of how the patient could meet the ever increasing costs of medical care. Have we not lost sight of the fact that even as our treatment for any given disease changes from year to year so do the economic conditions of the country and so do the trends of thought in the minds of men?

I believe that the people of America and their elected representatives, the Congress, are looking to American Medicine for leadership through the maze of contradictory statements that are engulfing them today in relation to the federal campaign for socialization of the country and medicine.

My plea is for American Medicine to relegate its scientific glories of the past to history, that we may work and plan for greater glories in the future. My plea is that American Medicine catch up with the times and demand a leadership that will evolve a plan, the Plan of American Medicine, so great and so far reaching that the people of the country will rally behind us and push the doctrine of federalization into the limbo of the forgotten.





CUSHMAN DAVIS HAAGENSEN, M.D., GUEST SPEAKER

The son of a country doctor, Dr. Cushman Davis Haagensen was born at Hillsboro, N. D., on July 6, 1900. He was educated at the University of North Dakota and at the Harvard Medical School, from which he received the degree of Doctor of Medicine in 1923. He began his hospital training with a surgical internship at the Boston City Hospital and successively served at the Boston Lying-In Hospital, the New Haven Hospital, and the Memorial Hospital and the Presbyterian Hospital in New York.

Since 1935 Dr. Haagensen has been associated with Columbia University College of Physicians and Surgeons. At that time he became a member of the attending staff of the Presbyterian Hospital, serving first as Instructor in Surgery and Assistant Attending Surgical Pathologist. In 1941, he was made Assistant Professor of Surgery, and in 1948, Associate Professor of Clinical Surgery. Also in 1948 he was appointed Co-ordinator of Cancer Teaching and he became director of the Medical Center's newly organized Institute of Cancer Research.

For many years this distinguished surgeon has been engaged both in clinical study of and laboratory research on cancer of the breast and he has written many papers on both aspects of this disease. He and his associates have recently announced the successful completion of their latest project in laboratory research, which has been concerned with the isolation and characterization of the milk factor of mammary carcinoma in mice. They have now begun the immunologic studies of the milk factor.

This eminent author is at present busily engaged in writing a book on tumors of the breast. He is the co-author of a book on the history of medicine entitled "A Hundred Years of Medicine," which was published in 1943.

The Journal of the Florida Medical Association

OWNED AND PUBLISHED BY FLORIDA MEDICAL ASSOCIATION
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SEVENTY-FIFTH ANNUAL MEETING

Marking three quarters of a century of existence, the Florida Medical Association will hold its annual convention this year on April 11, 12 and 13 at Belleair. The Belleview-Biltmore Hotel, attractive landmark of Florida's earlier days, will be the headquarters, housing all features of the meeting except the Smoker. The Starlight Room will be the scene of the three general and five scientific assemblies and the two meetings of the House of Delegates. The complete program is published in this number of The Journal.

Sixteen special groups will meet during the weekend preceding the opening of the Association's meeting. Some will hold sessions on Saturday afternoon or night and also on Sunday; others will meet only on Sunday. The facilities at the Belleview-Biltmore Hotel are ideal for these special group meetings. The program for 14 groups appears in this issue of The Journal. Program for the other 2 groups will appear in the printed program.

Dr. Chas. J. Collins, chairman of the Association's Committee on Scientific Work, together with the members of his committee, prepared the program for the scientific assemblies. The Board of Governors, at a meeting held in July, studied the resolution proposed by the Broward County Medical Society recommending discouragement of specialty societies and encouragement of specialty sections as a regular part of the scientific assemblies of the annual meeting. After hearing a report from a special committee and discussing at length the various aspects of the problem, the Board decided to have specialty society meetings scheduled for the Saturday and Sunday preceding the Association's annual meeting.

On a trial basis, it was decided to increase the number of papers at the scientific assemblies by arranging for five assembly meetings instead of three, the number held last year. This change makes provision for more than twenty scientific papers to be presented. Each of the specialty societies was requested to submit applications from members of its group for papers to be presented on the scientific program. Also, each specialty group received a communication requesting that its out-of-state guest speaker be invited to present a paper at one of the scientific assemblies. Most of the secretaries have been especially cooperative, and the majority of the specialty societies will be represented on the scientific assembly programs.

This plan makes provision for as many scientific papers from the state at large as heretofore and, in addition, provides for essayists from the specialty group societies. It is hoped that this new procedure will be fair to all concerned and will meet with general approval.

Members of the Hillsborough and Pinellas County Medical societies will be the hosts at the Smoker on Monday night, April 11, at the Clearwater City Auditorium. Preceding this annual occasion, the alumni and fraternity suppers will be enjoyed in the hotel's spacious dining room. The Annual Dinner of the Association will follow on Tuesday night at the hotel. In addition to participating in these social events featured annually,

the members and their guests have the opportunity to avail themselves of the diversified entertainment and recreational attractions which abound in the Clearwater-Tampa-St. Petersburg popular resort area.

The numerous technical exhibits will invite careful inspection. They are to be conveniently displayed in the hotel adjoining the main dining room.

NOTICE TO DELEGATES AND COMMITTEE CHAIRMEN

The House of Delegates will hold its first 1949 meeting on Tuesday, April 12, at 2:00 p.m. in the Starlight Room of the Belleview-Biltmore Hotel in Belleair. The 108 delegates are requested to assemble at the Credentials Committee table at 1:30 p.m. to present their credentials, fill out attendance cards and receive special badges. This table will be located at the entrance of the Starlight Room. It is required that each delegate present official credentials signed by the secretary of his county medical society. Delegates are to occupy seats in the section designated in order that they may be grouped together. Other members of the Association and guests are requested to occupy seats in another section of the room.

Chairmen of standing committees are urgently requested to be present on time so that their reports may be presented as scheduled in the official program, which is published in this issue of The Journal. Resolutions not included in the House of Delegates Handbook and supplemental additions to annual reports of chairmen of committees should be typed in duplicate and placed on the speaker's table immediately after they are presented.

It is highly important that delegates and committee chairmen note the time, the date and the place of this first meeting of the House of Delegates. Register at 1:30 p.m. and convene at 2:00 p.m., Tuesday, April 12, in the Starlight Room of the Belleview-Biltmore Hotel.

The second meeting of the House of Delegates will be held on Wednesday, April 13, at 10:30 a.m. Delegates are requested to fill out attendance cards for this meeting also at 10:00 a.m. at the entrance of the Starlight Room. These attendance cards are the delegates' official attendance records. The By-Laws prohibit an alternate from serving for any delegate who was seated at the first meeting of the House.

At 12:00 noon on Wednesday, in this second meeting of the House, the election of officers of the Association for the ensuing year will take place.

THE PHYSICIAN'S APPROACH TO THE PUBLIC

There seems to be a current theory, promoted no doubt by a very few, that those who know most about anything are prejudiced and hence are not reliable witnesses.

Physicians who know most about maintaining the public health and have spent a great portion of their lives studying health programs were not consulted by Mr. Ewing, Federal Security Administrator, who was appointed by President Truman to make a report on the nation's health.

Little wonder that many physicians feel very strongly on this subject. Little wonder that they, when called upon to speak in public, are apt to express themselves with much vigor and feeling. Little wonder that they sometimes give the impression that they harbor animosity and bear ill feeling toward those who disagree.

Care should be taken to guard against that manner, however, for by its use the physician may play into the hands of the smooth politician who makes it a policy to ingratiate himself with the public.

Likewise, the physician should guard against assuming the "wiser than thou" attitude and talking down to his listeners as if they had not enough intelligence to grasp the significant facts related to a technical subject.

The physician has right on his side and he need not be vindictive. He is upholding the American way of life; the way of the freedom-loving person who wishes to choose his own plan of action voluntarily and who wishes to have more than an indirect voice in working out his own way of life. Any informed physician can present convincing argument after argument to show that the proposed plans of compulsory health insurance are unsoundly based and will not work.

The physician can not only afford to keep his temper, but he will do better if he refrains from all display of anger and declines to engage in acrid debate. He certainly is justified in feeling strongly on the subject, but by speaking calmly with assurance, reason and friendliness he is much more apt to make his point and to win over a doubtful listener.

Have you paid your A. M. A. assessment of $25.00 through the secretary of your county medical society?

FORETASTE OF THINGS TO COME?

Free medicine—what does it cost? At present, one out of every six persons in the United States is entitled to some free medical service, to hospitalization, nursing, dental service. The present goal of the government planners is tax-paid medical care for everybody, as is now well known to the medical profession and the laity alike. Certain aspects of the trend toward fully socialized medicine, and the problems accompanying that trend, are emphasized in a report recently issued by the Commission on Organization of the Executive Branch of the Government, under the chairmanship of Herbert Hoover.[1] The country is plainly being forced into a decision upon the direction it chooses to take regarding the provision of medical care, the choice lying between full socialization with its attendant evils as in Britain, or partial socialization with some private control of medical service still guaranteed. The facts and figures revealed by the investigators for the Hoover Commission should have important bearing on the decision the Congress eventually will make.

That government agencies in 1948 spent $1,250,000,000 on medical services as against $250,000,000 in 1940 is enough in itself to give one pause for thought and for deep concern. A further increase is certain for this year aside from any broad plan for socialized medicine. In all, 44 federal agencies now deal with health and medicine; many of them overlap, and few are coordinated.

The building program of the various government agencies shows that parallel hospital systems are being rapidly expanded, with practically no coordination, by the Veterans Administration, the Public Health Service, the Army, the Navy and the Air Force. The Veterans Administration, for example, is pushing ahead on a $1,100,000,000 plan for hospital construction while there is a surplus of beds reported in military hospitals. In the New York area alone, with much unused capacity in the government's military hospitals, several federal agencies plan to build hospitals costing $100,000,000.

The average cost of government hospitals is from $20,000 to $30,000 per bed; of private hospitals, $16,000 per bed. This double standard is duplicated in time spent in hospitals, raising the per patient cost further. Last year, in private hospitals the average stay of patients was seven days; in county hospitals, partly tax-supported, seventeen days; and in federal hospitals, thirty days.

Waste and duplication in health facilities of typical cities of the United States are cited in the report. In New York City plans are afoot to double the capacity of federal hospitals when, an official survey shows, there is already much unused capacity. In New Orleans, more than half of the armed forces' medical personnel could be saved if the local government hospital setup were unified. In Los Angeles the same is true, and five Navy hospitals among the twelve federal hospitals there could be discontinued if nonmilitary patients were removed and duplication ended. In San Diego, with ten federal hospitals in the area, the patients number just about the operating capacity of one of those hospitals, run by the Navy with much unused capacity. The same pyramiding of socialized hospital facilities exists in other areas. In Houston, for example, a new $25,000,000 Veterans Administration hospital is about to be erected next to an equally large Navy hospital that has for two years now been filled only to 10 per cent of its capacity with Navy patients. There is overlapping of the nation's socialized hospital facilities in nearly all parts of the United States.

This official picture of the trend to date of socialized medicine in the country is one of waste and duplication at the taxpayer's expense. Whether the present administration's plan for a new government superstructure to coordinate all government medical care, plus a superimposed program of compulsory health insurance for everybody, becomes law is for the nation's legislators to determine.

One obstacle to be surmounted is the determination of the armed forces, with 276 hospitals supported by tax dollars, to keep control over its medical setup. Another is strong local pressure to prevent control from going to a central agency, exerted by areas wanting to get or keep Veterans Administration hospitals, numbering 125 so far. Other special groups, such as the Interior Department with its 67 hospitals mostly for the use of Indians on reservations, insist upon retaining control of hospitals in their particular field.

A big stumbling block, and one that is steadily gaining momentum, is the vigorous opposition of members of the medical profession to any form of compulsory health insurance. The decision, one way or the other, now must be made by the Congress. The outcome rests largely on whether or not means can be found to overcome or get around

1. Free Medicine: What It Costs. The United States News and World Report, Jan. 7, 1949, p. 15.

these objections. Every member of the Florida Medical Association should do all in his power to see to it that Florida's representatives in Washington think straight and vote right on the vital issue of the regimentation of medicine in this country.

THE MOTHER TONGUE
A NEGLECTED ASSET

"Wanted—A Better Command of English" is coming to be a slogan in the business world. And well it may. More than four fifths of business transactions are conducted by means of letters and over a hundred million dollars was spent last year alone by American firms for printed material, according to a well informed source. Too, business is finding that ability to command English effectively is as important in speaking as in writing. Words poorly chosen may lose a contract or precipitate labor trouble. Management complains of deficiency in these skills among its junior executives and is more and more placing a high rating on writing and speaking abilities.

The schools and colleges, partly responsible for these deficiencies, will be quick to respond to renewed interest evinced by the public in the masters of English prose, once the public realizes the value of improved speech and writing as reflected in salary increases and promotions. But fundamentally, the public must first readjust its pattern of values. Traditionally it is the American way in evaluating accomplishment to set high value on scientific achievement, technical knowledge and mechanical ingenuity at the expense of the arts of expression.

This lesson from the business world may well be taken to heart by the medical world. Assailed from without by the very real threat of regimentation, the medical profession has need of the written word and the spoken word as never before. They are the tools by which physicians may acquaint the laity with the evils inherent in the movement that would rob the physician of his cherished freedom in the practice of his profession and eventually enslave the nation. Medical public relations has as its stock in trade the printed page, the polished address on a timely subject, the right word spoken in the right place at the right time.

Likewise from within, medicine as well as business can profit by better command of English. In these days of astounding medical progress, deprive the physician of his medical literature and lectures and where would he be professionally? Improve these channels of professional advancement and they, in turn, improve the physician and thereby elevate the level of the profession as a whole. The essayist on a medical program holds —or does not hold—his audience both by what he says and how he says it. On the same basis, his paper in print attracts or does not attract the reader.

Better command of the English language deserves top rating, not only for the medical student and his professors, not only for the young doctor just starting out, not only for the medical journalist and the medical lecturer, but for every physician. The doctor who, revering his profession, desires to improve it through self improvement and wishes to enlighten his public regarding its achievements and rightful place in a free American economy will set himself to cultivate this neglected asset.

V. A. DIRECTIVE ON TREATMENT OF MALARIA CASES

The attention of the Association's fee-designated Veterans Administration Physicians is called to the following extract of a directive from the Veterans Administration Branch Office on the treatment of malaria cases.

"When requesting authority from the Veterans Administration to treat a veteran with a clinical diagnosis of malaria, your request should be accompanied with corroborative evidence of appropriate laboratory tests. If laboratory facilities are not otherwise available, authority should be requested to send the veteran, or thick blood smears to the Regional Office, or to utilize the services of a private laboratory of recognized standing.

"When a veteran has had four or more relapses due to malaria he should be admitted to the nearest veterans' hospital.

"If the veteran's symptoms require treatment, but blood smear is negative for malaria, an application for hospitalization should be completed and forwarded to the Regional Office. Arrangements will then be made to admit the veteran to a veterans' hospital for diagnostic study, and if repeated blood smears continue to be negative, careful study may be expected to result in a correct diagnosis of his ailment and efficient treatment thereof."

MIDWINTER MEETING OF FLORIDA SOCIETY OF OPHTHALMOLOGY AND OTOLARYNGOLOGY

The Florida Society of Ophthalmology and Otolaryngology held its second midwinter meeting at the Robert Richter Hotel in Miami Beach on Jan. 12, 1949, in conjunction with the Midwinter Seminar in Ophthalmology and Otolaryngology sponsored by the Graduate School of Medicine, of the University of Florida, which was in session there during the week of January 10.

The scientific session convened at 8 p.m., and the president, Dr. Bascom H. Palmer of Miami, welcomed the members and guests. Dr. Paul H. Holinger of Chicago then presented a remarkable motion picture entitled "The Function of the Ear in Health and Disease," by Dr. H. G. Kobrak and Joseph E. Hind.

The guest speakers were Dr. John H. Dunnington of New York and Dr. A. C. Furstenberg of Ann Arbor. "Thoughts on Some Surgical Subjects" was the title of Dr. Dunnington's address. Dr. Furstenberg spoke on "A Clinical Consideration of Tumors and Cysts of Teratological Origin."

There were present 45 members of the Society and many guests, bringing the total attendance of physicians to approximately 175. The wives of the members and of the visiting physicians were guests for the showing of the motion picture. Earlier in the evening, at the cocktail hour, the Society and the Seminar entertained jointly for the many distinguished visitors from all over the nation.

APPLICATION BLANKS FOR ACADEMY OF GENERAL PRACTICE

Many members of state medical societies have written to their journals inquiring as to how they can procure application blanks for membership in the American Academy of General Practice. The national headquarters office is located at 231 West 47th Street, Kansas City 2, Mo., and Mr. Mac F. Cahal is the executive secretary. The headquarters office will be glad to forward application blanks to practitioners living in states with no state chapter.

But where a state chapter exists, blanks must be obtained from the secretary of the respective constituent state chapter. The secretary of the Florida chapter is Dr. Norris M. Beasley, 380 S. E. Second Street, Ft. Lauderdale.

DIABETES SEMINAR TO BE HELD IN JACKSONVILLE, MARCH 28-29

In cooperation with the Department of Medicine of the Graduate School of the University of Florida and the Clinical Society of the Duval County Diabetes Association, the U. S. Public Health Service is presenting a seminar on diabetes at the George Washington Hotel, Jacksonville, on March 28 and 29.

The speakers will be as follows: Dr. Charles H. Best, co-discoverer of insulin, director of the Banting and Best Department of Medical Research, University of Toronto, and president of the American Diabetes Association; Dr. Elliott P. Joslin, medical director of Baker Clinic, Boston, and author of classic textbook on diabetes treatment; Dr. Joseph H. Barach, professor of medicine at the University of Pittsburgh, director of Falk Clinic, and chairman of Metabolism and Endocrinology Study Section of the Research Grants Division of the National Institutes of Health; and Dr. John A. Reed, assistant clinical professor of medicine at George Washington University, and attending physician and director of the Outpatient Department of the George Washington University Hospital.

Detailed programs are being sent to secretaries of medical societies in the Southeastern States area. There will be no registration fee. Hotel reservations should be made through Dr. Malcolm J. Ford, Diabetes Demonstration Unit, Box 210, Jacksonville.

YOUR BLUE SHIELD

We wish to direct attention of Blue Shield physicians to the dangers of delayed billings. Unreported bills for services rendered by physicians to Blue Shield members constitute concealed liabilities which affect the financial position of the organization. Participating physicians are urged to submit claims for Blue Shield members promptly, and when billing the plan to use the plan's "Doctor's Service Report." Billings sent in to the plan on physicians' statements and not on official Blue Shield forms cause unnecessary delay in the processing of the claim.

From time to time the Blue Shield Plan has received claims from subscribers who were referred by Blue Shield physicians to doctors who are not connected with the plan. Situations of this kind prove most embarrassing as these claims cannot

be honored. Participating physicians are requested to keep in mind that when it is necessary to refer a patient to another doctor, whenever possible this doctor should be participating in the Blue Shield Plan; if not, the referring physician is asked to urge the nonparticipating physician to sign an agreement with the plan as Blue Shield subscribers naturally expect such claims to be paid, assuming that Blue Shield physicians will recommend fellow Blue Shield physicians.

Some participating physicians are destroying public confidence in the Blue Shield voluntary plan of prepaid medical care by billing Blue Shield subscribers for services instead of sending "Doctor's Service Reports" to the plan. Please do not bill a Blue Shield subscriber for professional services for which he owes you in connection with the case until you have received the Blue Shield payment. When a physician requests payment from a Blue Shield patient prior to the time that the plan reimburses him, he defeats the objective of voluntary plans, which is to ease the financial impact of serious illness. Recently a number of Blue Shield subscribers have complained bitterly because they have received bills when the physician should have sent a "Doctor's Service Report" to the plan for payment. As a participating physician, your obligation is to render a "Doctor's Service Report" covering your services to the office of the Blue Shield Plan. Payment will be sent directly to you. Most participating physicians are following the proper procedure, but too many are consistently disregarding it. The result —much of the good will toward the medical profession, created by Blue Shield, is being destroyed. A voluntary plan of prepaid medical care cannot succeed except by having the support of the individual members of the medical profession.

In reviewing statistics on the year just past it is interesting to note the rapid growth of the Blue Shield Plan in Florida and the amount of benefits received by subscribers and participating physicians. Enrolment in the plan more than doubled during 1948, with an increase of 123 per cent. At the end of 1947 there were 36,402 members enrolled. During 1948 the plan added 44,868 members, bringing the total enrolment to 81,270. Benefits in the amount of $315,000 were paid to doctors for the care of Blue Shield members during 1948. Two hundred and fifty physicians signed agreements during 1948 to participate in the Florida Blue Shield Plan, bringing the total number of participating physicians to 1,475. While these figures are impressive, there is still a big job to be done. Doctors opposed to government control of the medical profession know that voluntary prepayment plans are the only practical alternative to a bureaucratic system of medical care. We of Blue Shield believe that care by an interested personal physician offers the best method of furnishing good medical care. We want every doctor in the state to participate in this plan. That is why we believe every doctor should impress upon his colleagues the importance of participating as a Blue Shield physician. We of the Blue Shield know that benefits to both physicians and subscribers can be broadened as membership grows. That is why we believe every doctor should do his utmost in furthering enrolment of subscribers in the Blue Shield Plan. The public will regard with greater respect and confidence a medical profession united in a workable plan whose objective is making good medical care available to all.

BIRTHS, MARRIAGES AND DEATHS

MARRIAGES

Dr. Lawrence G. Hebel of Palatka and Miss Lester E. Faulk of Dobson, N. C., were married on Jan. 7, 1949, in Palatka.

BIRTHS

Dr. and Mrs. Nelson A. Murray, Jacksonville, announce the birth of a daughter, Marlene, on Jan. 6, 1949.

Dr. and Mrs. Theodore J. Kaminski, Melbourne, announce the birth of a daughter, Marilyn Kay, on Dec. 23, 1948.

Dr. and Mrs. Jess V. Cohn, Indianapolis, Ind., announce the birth of a son, Jess Victor, Jr., on Jan. 17, 1949.

Dr. and Mrs. Carl M. Midkiff, Miami, announce the birth of a daughter, Karen, on Nov. 29, 1948.

Dr. and Mrs. Robert M. Oliver, Miami, announce the birth of a daughter, Elizabeth Cherry, on Nov. 23, 1948.

Dr. and Mrs. Samuel M. Day, Jr., Jacksonville, announce the birth of a daughter on Jan. 24, 1949.

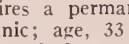
Dr. and Mrs. James F. Lyons, Coral Gables, announce the birth of a daughter, Louise Elizabeth, on Aug. 19, 1948.

DEATHS—MEMBERS

Dr. James R. Norton, Port St. Joe	Dec. 29, 1948
Dr. John L. Redding, Orlando	Sept. 29, 1948
Dr. Haynsworth D. Clark, Ft. Pierce	Jan. 15, 1949
Dr. William J. Buck, Belle Glade	Jan. 13, 1949
Dr. Orville H. Cribbins, Sarasota	Jan. 25, 1949

DEATHS—OTHER DOCTORS

Dr. Edwin L. Stevens, Penney Farms	Jan. 16, 1949
Dr. John Keely, Jacksonville	Jan. 23, 1949



SURGEON desires a permanent association with an individual or a clinic; age, 33; married; finishing five year surgical residency in large, teaching southeastern hospital which is connected with a medical school. Write 69-24, P. O. Box 1018, Jacksonville, Fla.

STATE NEWS ITEMS

The efforts of the Escambia County Medical Society to correct the local shortage of hospital beds has resulted in the Escambia General Hospital of Pensacola, which was organized and planned by the society. The Staff elected Dr. George W. Morse, president, Dr. Charles A. Born, vice president, and Dr. Joseph W. Douglas, secretary-treasurer. Dr. Mozart A. Lischkoff is one of the trustees appointed by Gov. Millard Caldwell.

The hospital is a 78 bed institution with facilities for medical, surgical, contagious and psychopathic cases. It has an out-patient department which houses the city and county health units, the cancer clinic, the eye, ear, nose and throat and the orthopedic clinics.

Dr. Arthur J. Butt, Jr., of Pensacola recently presented a paper entitled, "Oliguria and Anuria Due to Sulfonamides," before the meeting of the Staff and Fellows of the Ochsner Clinic in New Orleans.

Drs. C. Frank Chunn of Tampa and Walter C. Jones of Miami were speakers at the sectional meeting of the American College of Surgeons which was held in Edgewater Park, Miss., in January.

The Florida Trudeau Society will hold its annual meeting in conjunction with the Annual Conference of the Florida Tuberculosis and Health Association at Tampa on April 21 and 22. Dr. Isaac B. Cippes of Miami is president of the society.

The society has scheduled a half day clinical-radiological conference and physicians with interesting films are invited to present them. The scientific meeting will be presided over by Dr. Cippes. An outstanding speaker on some phase of clinical tuberculosis is scheduled to address the conference.

Headquarters for the meeting will be the Hillsborough Hotel, Tampa.

Dr. Willett E. Wentzel of Bradenton recently was the guest speaker at the meeting of nurses of District 19 in Bradenton. Dr. Wentzel discussed the history, treatment and various stages of venereal diseases.

Dr. Joseph S. Stewart of Miami represented Florida on the Committee of Fifty-Three Physicians which met at the headquarters of the American Medical Association in Chicago, Saturday, February 12. Dr. Robert B. McIver and Mr. Ernest R. Gibson of Jacksonville met with the Committee of Fifty-Three Physicians.

Dr. Herbert L. Bryans of Pensacola was re-elected president of the Florida State Board of Health on February 8. Mr. William Parr of Tampa was re-elected vice president. Other board members are Dr. Robert B. McIver of Jacksonville, Dr. Mark F. Boyd of Tallahassee and J. E. Edwards, D.D.S., of Miami.

Dr. J. Dillard Workman of Live Oak has returned to practice after two years' retirement because of ill health. Dr. Workman will specialize in internal medicine, pediatrics and geriatrics and will share the offices of Dr. C. LeRoy Adams, Jr.

Dr. S. L. Watson, Jr., of Lakeland spoke on sex education at a recent meeting of the Lakeland Kiwanis Club. He stressed the obligation of parents to inform their children on matters of sex.

Dr. Frederick LeDrew has moved his offices to 802 Chamber of Commerce Building, Miami. His practice is limited to psychiatry.

Dr. Rollin D. Thompson, former general superintendent and medical director of the three Florida State Tuberculosis Sanatoriums, has accepted a position as superintendent and medical director of the La Vina Sanatorium in Pasadena, Calif.

Dr. James V. Freeman of Jacksonville has been elected chairman of the executive committee of the American Cancer Society's Duval County unit. Other Association members who will serve on the committee are Drs. Robert H. Nickau, Edward Canipelli, A. Judson Graves, Wilbur C. Sumner, and Roger F. Sondag. Dr. Graves will serve as chairman of the speakers' bureau.

Dr. Wm. E. Van Landingham of West Palm Beach recently addressed members of the Pahokee Parent Teacher's Association. He spoke on "The Healthy Family."

NEW MEMBERS

The following doctors have joined the State Association through their respective county medical societies.

Beaumont, Godfrey L., Sebring
Buchwald, Merwin E., Madison
Campbell, James A., Miami
Carver, Joseph R., Branford
Cawthon, William D., DeFuniak Springs
Chapman, Jules B., West Palm Beach
Craig, James A., Naples
DuRant, Julian M., Madison
Grizzard, Vernon T., Jr., Jacksonville
Herz, Ralph, Key West
Johnson, Charles A., Jr., Clearwater
Kirsh, David, Miami
Landrum, Louis G., Lake City
LaRoche, Laurent L., Cocoa
McQuagge, Albert E., Marianna
Parker, Harold E., Arcadia
Pessolano, Louis C., Miami Springs
Raynolds, Arthur H., Bay Pines
Roland, Paul S., Miami Beach
Sasso, Robert M., Lake City
Schneider, Lawrence J., Daytona Beach
Sheppard, Ben J., Coral Gables
Sinnott, Richard F., Ft. Pierce
Snyder, Grayson C., Blountstown
Stevens, Theodore R., Miami
Unger, Paul N., Miami Beach
York, Clifton G., Lake City

COMPONENT SOCIETY NOTES

BREVARD

At the January 18 meeting of the Brevard County Medical Society, Dr. Harold A. Miller, formerly of Pittsburgh, now living in retirement in Cocoa, was the guest speaker. Dr. Miller related his experiences with government controlled medicine in Germany and heartily endorsed all possible action to combat similar governmental control in the United States.

DESOTO-HARDEE-HIGHLANDS-CHARLOTTE-GLADES

The regular meeting of the DeSoto-Hardee-Highlands-Charlotte-Glades County Medical Society was held on January 11 at Aqua Vitae Springs. Dr. James R. Boulware, Jr., of Lakeland, as the guest speaker, presented a paper on "Immunization."

Members present included Drs. Harold S. Agnew, Roland W. Banks, Henry P. Bevis, Isaac W. Chandler, Hubert W. Coleman, Miles A. Collier, Merle C. Kayton, Charles H. Kirkpatrick, Carl J. Larsen, Leldon W. Martin, Wesley S. Pyatt, Zaven M. Seron, John A. Simmons, James G. Smith, Jr., Stanley K. Wallace and Howard V. Weems. Dr. Boulware and Dr. James T. Shelden of Lakeland were guests.

DUVAL

At the January meeting of the Duval County Medical Society, Dr. Lawrence E. Geeslin and Dr. Edward Canipelli presented a symposium on "Thrombophlebitis," which was illustrated by slides. The paper was discussed by Drs. Karl B. Hanson, Turner Z. Cason, Kenneth A. Morris and F. Gordon King.

Dr. Charles F. Henley, vice president, presided at the business meeting in the absence of Dr. Raymond R. Killinger, president, who, as a lieutenant colonel on Gov. Fuller Warren's staff, attended the inauguration in Tallahassee.

FRANKLIN-GULF

Officers who will serve the Franklin-Gulf County Medical Society during 1949 include Drs. Albert L. Ward, president, Donald H. Anderson, secretary, and William P. Blackmon, treasurer.

MARION

The regular monthly meeting of the Marion County Medical Society was held at "The 1890 House" in Ocala on January 19. Sixteen members were present, as well as a guest, Dr. Charles H. Blandford, director of the Marion County Health Unit.

At the request of Dr. Blandford, Dr. Robert E. Thompson, president, appointed a liaison committee to the county health unit. The members are Drs. Eugene G. Peek, Sr., Henry L. Harrell and Bertrand F. Drake. Dr. Blandford submitted to this committee a proposed program of work to be done by the Marion County Health Unit.

Drs. Richard C. Cumming, John N. Moore and Carl S. Lytle were appointed to the cancer committee. Dr. Cumming was re-elected public relations officer for 1949.

Members present were Drs. William H. Anderson, Hugh H. Barfield, Richard C. Cumming, Bertrand F. Drake, William H. Garvin, Jr., Henry L. Harrell, Eaton G. Lindner, Carl S. Lytle,

William J. McGovern, John N. Moore, Robbins Nettles, Eugene G. Peek, Eugene G. Peek, Jr., Ralph E. Russell, Thos. H. Wallis and Harry F. Watt.

PUTNAM

At a recent meeting of the Putnam County Medical Society, members were read a letter from Dorothy Thompson, columnist, on socialized medicine. Present at the meeting were Drs. James W. Brantley, Grover C. Collins, Edward W. Ford, Lawrence G. Hebel, Bernard E. Kane and Claude M. Knight.

All members of the society have paid Association dues for the year 1949. Congratulations!

SARASOTA-MANATEE

Attending the regular meeting of the Sarasota County Medical Society and the Manatee County Medical Society on Jan. 11, 1949 were the local state legislators, Senator William J. Ray of Bradenton and Representatives J. Ben Fuqua of Palmetto, Joe Bill Rood of Bradenton and James A. Haley of Sarasota. A program acquainting them with medical problems, both local and national, was presented. Dr. Lowrie W. Blake and Dr. Stanley T. Martin discussed progress to date on the building of hospitals for the area. Dr. Joseph Halton read a paper on the attempted socialization of the nation's entire economy, including medicine in particular, setting forth clearly the evils inherent in such a system. The entire situation relating to naturopaths was also discussed. Dr. John M. Butcher outlined the educational requirements of this group, and several physicians cited cases illustrating naturopathic methods of treatment.

Each of the legislators present spoke briefly. All assured the physicians of their support in dealing with legislation of medical import at the coming session of the legislature. Another guest, Mr. Ernest R. Gibson of Jacksonville, executive secretary of the Florida Academy of Public Medicine, was introduced.

WASHINGTON-HOLMES

Officers re-elected to serve the Washington-Holmes County Medical Society for 1949 are Dr. N. J. Dawkins of Vernon, president, and Dr. Bayllye W. Dalton of Chipley, secretary-treasurer.

All members of the society have paid 1949 Association dues. This cooperation is greatly appreciated.

FLORIDA ACADEMY OF PUBLIC MEDICINE
PUBLIC RELATIONS FOR
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AMA ASSESSMENT AND THE PRESS

As soon as it became known that the American Medical Association had decided to assess each of its active members $25 for an educational campaign to combat the threat of socialized medicine, there was a variety of reactions from the public press. Opinions varied from complete agreement and commendation to scathing denunciation.

Such was the immediate reaction. As time has gone on, editorial comment in both newspapers and magazines has analyzed the situation more critically. At this writing there appears to be an attitude of watchful waiting and a plea for presentation of facts unobscured by effusive propaganda. Such highly respected publications as the Saturday Evening Post and the New York Daily News have taken Federal Security Administrator Oscar Ewing to task for unwarranted maligning of the medical profession of this country.

In an attempt to arrive at some determination as to the views of the press in Florida a few editors were selected at random and personally contacted in regard to the issue of compulsory health insurance and the AMA assessment. These editors ranged from those of the largest metropolitan dailies to the smaller of the weekly newspapers.

As a result, certain generalizations may be reached which it is safe to offer as reflecting opinions of the majority of the newsmen approached. The sequence as given here is purely arbitrary and is not necessarily the order of importance.

First, newspaper people as a group do not want

socialized medicine. Generally they are averse to regimentation and government interference in the private lives and businesses of the American people. Moreover, they are inclined to look upon the socialization of medicine as the entering wedge for government regulation of other activities, even the press itself.

Second, this group of influential Americans are not convinced that compulsory health insurance is the answer to improvement of medical care in the United States. Nor are they quite certain that we should be satisfied with the present status quo. There is an attitude of watchful waiting—waiting for the smoke produced by heated declarations on both sides to clear, waiting for substantiated information.

Third, there is a fairly general agreement that the medical profession has equal rights with other groups to raise funds from among its own members to conduct an educational campaign, and to attempt to influence legislation to conform to that which it deems advisable in the interests of the profession and for the protection of the public health.

Again, in the fourth place, the press is not likely to continue to take a neutral position. Each newspaper and magazine will set its editorial policy based upon the evidence presented according to the interpretation of its editorial staff. The gentlemen of the press are likely to see eye to eye with the medical profession in this matter providing the doctors present a constructive program, not merely a negative one. To convince most of them, a workable substitute must be provided for that which is offered by the advocates of compulsory health insurance. There must be proof that voluntary health plans have the full support of the physicians of this country, and that such plans can and will do the job. A typical comment is, "Show us that the doctors are for something."

Finally, there is a conviction that perhaps the emphasis and impetus to this educational campaign are in the wrong place. There is the feeling that the local medical society should be the chief ball carrier in this contest. They reason that people will listen more readily to their own doctors and if local physicians are making the statements, they will be well received. Their advice is to go to the "grass roots."

Actually that is what is being done today to a greater and ever greater degree. Obviously, the campaign is yet not of sufficient emphasis in most places to impress greatly the fourth estate. Aggressive local participation along the lines suggested by national and state medical leaders is likely to produce cooperation from the home press beyond the greatest expectation. It will be the people back home who determine the way Senators and Congressmen vote in the final analysis, not the representatives of American medicine in the Washington office. These people are concerned; they are also confused. But they are fundamentally honest and quite capable of intelligent decision if they get facts from people whom they are certain they can trust.

WILLIAM HOLLIS BRADFORD

Dr. William H. Bradford of Chevy Chase, Md., died on Nov. 15, 1948 in Cleveland. He was 47 years of age.

Dr. Bradford received his medical education at the University of Cincinnati College of Medicine, from which he was graduated in 1928. He had served as chief medical officer and as manager of the Brecksville Veterans Hospital in Ohio.

He was a member of the Pinellas County Medical Society and the Florida Medical Association and was a fellow of the American Medical Association.

His death came three days after that of his brother, Roark Bradford, author of the book used as a basis for the stage play, "Green Pastures."

BRUCE FOWLER BUTLER

Dr. Bruce F. Butler of Hollywood died on Nov. 12, 1948 at Duke University Hospital in Durham, N. C. He was 61 years of age.

Dr. Butler was born in 1887 in Clinton, N. C. He was graduated from the University College of Medicine, Richmond, Va., in 1911. In 1925 Dr. Butler moved his offices from Clinton to Hollywood, where he practiced until the time of his death.

He was widely known for his mosquito control work in Hollywood shortly after the founding of the city. He served as city physician and was one of the first commissioners of the Broward County port authority. During the first world war he served in the Army medical corps and later, in 1930, became commander of the Hollywood post of the American Legion. He also was a member of

the Hollywood Lodge F. & A. M., and the Rotary Club, which he served as president during 1933 and 1934.

Dr. Butler was a member of the Broward County Medical Society, the Florida Medical Association and the American Medical Association.

Survivors include his widow, Mrs. Edna S. Butler; two sons, Robert B. Butler and Henry T. Butler, all of Hollywood; two daughters, Mrs. Patricia King, Augusta, Ga., and Miss Sally Butler, Hollywood; a brother, Fulton Butler, and a sister, Mrs. Nancy Holmes, both of Rich Square, N. C.

NOBLE ALVIN UPCHURCH

Dr. Noble A. Upchurch of Jacksonville died on Dec. 31, 1948 at his residence. He was 71 years of age.

Born in Nassau County on May 31, 1877, Dr. Upchurch was the son of Nathaniel Smith Upchurch and Sarah E. Parker Upchurch. He was of Scotch-Irish descent, the first Upchurch family locating in the Cape Fear section of North Carolina prior to the American Revolution, in which his greatgrandfather served. His father arrived in Florida in 1856 and settled in Nassau County. During the War Between the States he built the first telegraph line in that section and over it maintained communication for the Confederate Army.

Dr. Upchurch received his early education from private tutors and his academic training in Atlanta. In 1900 he was graduated with honors from the Vanderbilt University School of Medicine. He did postgraduate work at Tulane University School of Medicine in 1903, and at Harvard Medical School in 1919 and at several later periods.

Immediately after his graduation, Dr. Upchurch practiced for a few months in Kissimmee. In 1901 he located permanently in Jacksonville, where he enjoyed a distinguished career in his chosen profession for nearly half a century. For eighteen years—from 1925 to 1943—he served as health officer of the City of Jacksonville, retiring on Jan. 1, 1943 because of ill health. He was a member of the staff of St. Luke's and St. Vincent's hospitals and served as physician to the athletic department of the Old Duval High School. He was also medical examiner for a number of life insurance companies. He was affiliated with the Masonic Order and was a member of the Civitan Club and the University Club.

Dr. Upchurch was a past president of the Duval County Medical Society, a member of the Florida Medical Association and a fellow of the American Medical Association. He served the American Public Health Association officially in various capacities and in 1930 was made a fellow of that organization in recognition of his outstanding contributions in the field of Public Health. The Cuban government recognized his work by granting him the Finlay Award and citing him for his achievements.

In 1908, Dr. Upchurch married Miss Susan Culpepper of Thomasville, Ga., who survives him. Also surviving is a daughter, Miss Susanne Upchurch.

JAMES ROBERT NORTON

Dr. James R. Norton of Port St. Joe died suddenly on Dec. 29, 1948, following a heart attack which he suffered white attending Dr. Thomas Meriwether at his home in Wewahitchka. He was 43 years of age.

Dr. Norton was graduated from the University of Arkansas School of Medicine in 1936 and spent a year as an intern at St. Luke's Hospital in Jacksonville. In 1937 he opened offices in Port St. Joe, where he practiced continuously until the time of his death.

The young physician was a charter member and past president of the Port St. Joe Kiwanis Club. At the time of his death he was lieutenant-governor of District Two of Kiwanis. He was also a member of the Masonic Order and the Morocco Temple of the Shrine.

Dr. Norton was a member of the Franklin-Gulf County Medical Society, which he had served as secretary since 1940. He was also a member of the Florida Medical Association and a fellow of the American Medical Association.

Survivors include a son, a daughter, and his mother, Mrs. Mary Norton, all of Harrison, Ark.; three brothers, Dennis of Bartelsville, Okla., Clyde and Woody of Harrison; and two sisters, Gussie and Sue, both of Harrison.

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LEON-GADSDEN-LIBERTY-WAKULLA-JEFFERSON COUNTY AUXILIARY IS ORGANIZED

Mrs. Lee E. Parmley of Winter Haven, president of the Woman's Auxiliary to the Florida Medical Association, met with the wives of members of the Leon-Gadsden-Liberty-Wakulla-Jefferson County Medical Society on November 29 for the purpose of organizing an auxiliary.

Officers of the newly-formed auxiliary are Mrs. Merritt R. Clements of Tallahassee, president; Mrs. Taylor W. Griffin of Quincy, vice president; Mrs. William D. Rogers of Chattahoochee, secretary; Mrs. Charles F. James, Jr., of Tallahassee, treasurer. Mrs. Ernest W. Ekermeyer of Tallahassee is chairman of the membership committee, and Mrs. Benjamin A. Wilkinson of Tallahassee is program chairman.

Accompanying Mrs. Parmley was Mrs. Wylie L. Tillis of Lakeland, treasurer of the state auxiliary.

DUVAL COUNTY AUXILIARY MEETS

Dr. Raymond R. Killinger, president of the Duval County Medical Society, recently addressed members of the Duval County auxiliary. He spoke on "The Problem of Socialized Medicine."

At the business meeting, Mrs. Raymond R. Killinger was asked to head a speakers' committee, which is to help acquaint various groups with the problems of socialized medicine. Mrs. Victor A. Hughes was appointed chairman of a committee on suggested revisions of the auxiliary's By-Laws.

The group voted to donate $50.00 to Hope Haven Hospital for shoes for the children.

THE TECHNICAL EXHIBIT

One feature that always adds materially to the success of an annual meeting is the technical exhibit. Every firm represented in the display features products of particular interest to the physician. Make a special effort to visit each booth at some time during the convention and register your name with the attending representative.

A. S. ALOE COMPANY—12

The A. S. Aloe Company is showing a representative cross section of surgical and laboratory equipment and supplies used in a modern doctor's office. Featured will be a selection of government surplus instruments fully guaranteed and now selling at one half the regular current list price.

AMERICAN OPTICAL COMPANY—34

Physicians are invited to visit the American Optical Company booth where ophthalmic and scientific instruments will be displayed and demonstrated.

ANDERSON SURGICAL SUPPLY COMPANY—11

Physicians are invited to see items of special interest to doctors at the Anderson Surgical Supply Company booth. Several pieces of new equipment made by manufacturers of furniture for physicians' offices will be shown. Physicians are welcome to visit the St. Petersburg and Tampa stores while they are in the area.

BILHUBER-KNOLL CORP.—40

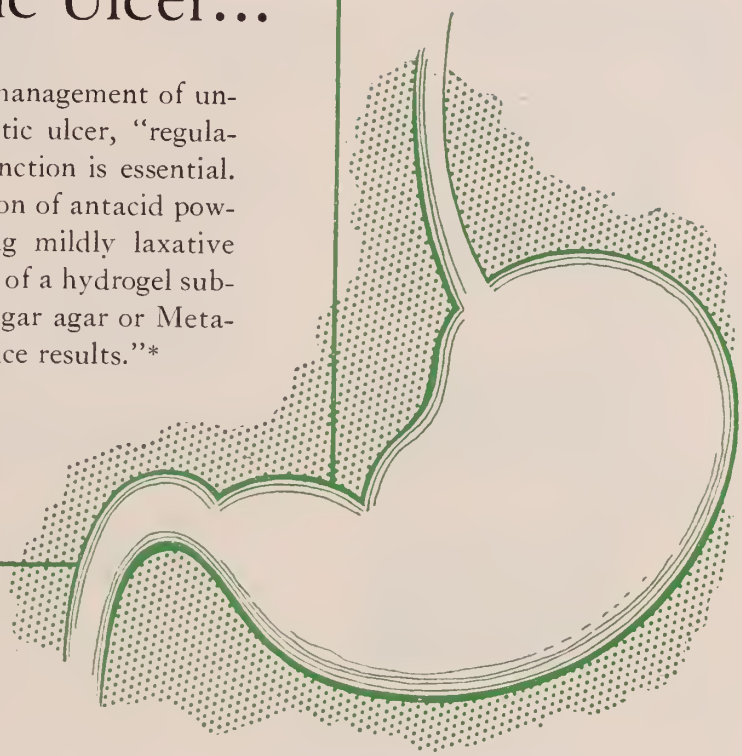
The fine medicinal chemicals which fill a most important place in the physician's armamentarium of dependable and useful medication, Bromural, Dilaudid, Metrazol, Octin, Theocalcin, and so forth will be found at the Bilhuber-Knoll booth. Visit their exhibit for the latest developments among these and their other prescription chemicals. Each is adaptable for prescribing alone or in combinations to meet the needs of the individual patient.

THE BORDEN COMPANY—23

A new improved, better than ever, Biolac is presented, better nutritionally and better physically. Unchanged are the dilutions, analysis, caloric values, vitamin fortification, and ease of feeding. This new improved Biolac, a liquid modified milk for infant feeding, brings the latest findings of nutritional science . . . at no increase in cost. Likewise exhibited will be the long established products, Mull-Soy, Dryco, Beta Lactose, Gerilac, Klim and Merrell-Soule special milks.

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In the medical management of uncomplicated peptic ulcer, "regulation of bowel function is essential. . . . A combination of antacid powders . . . having mildly laxative effects or the use of a hydrogel substance, such as agar agar or Metamucil, will produce results."*



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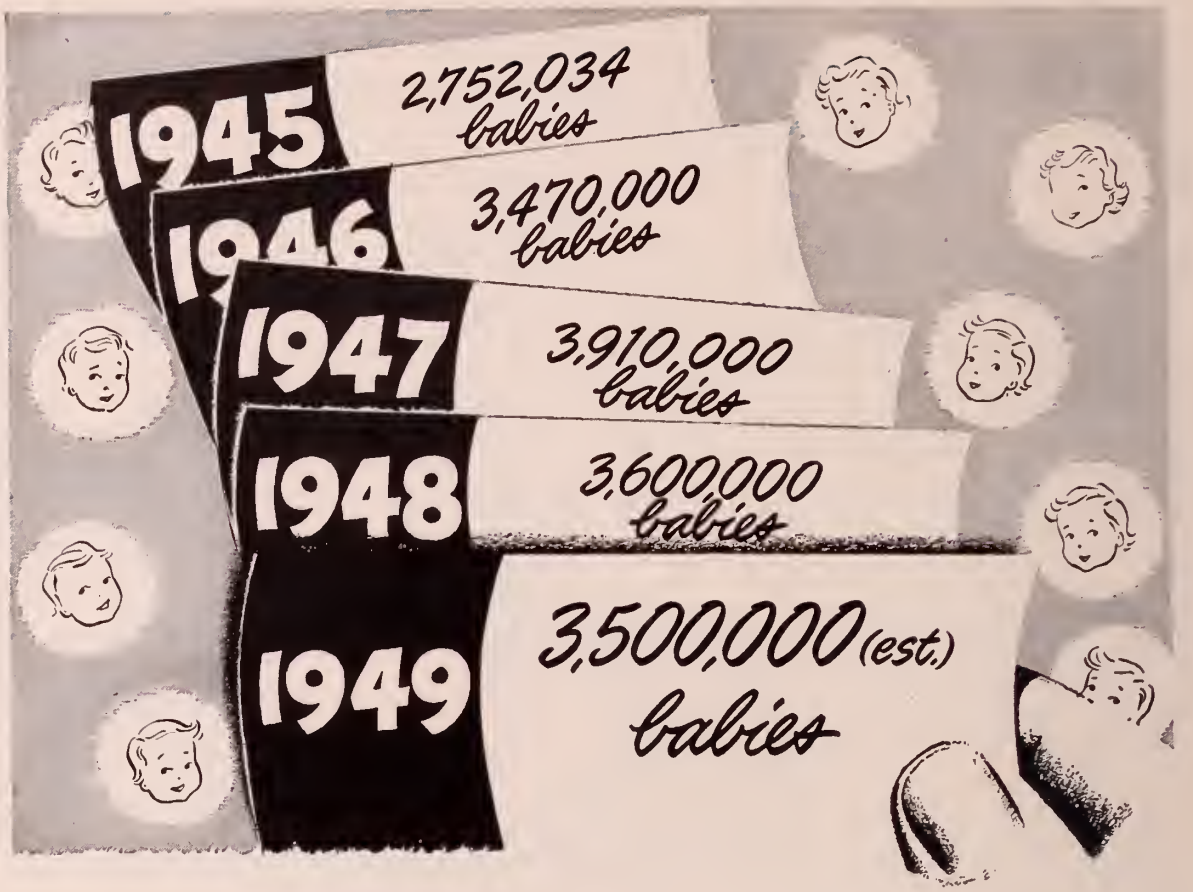
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*Gerendasy, J.: Modern Treatment of Peptic Ulcer, J. M. Soc. New Jersey *43*:84 (March) 1946.



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BYRON THOMPSON & COMPANY, INC.—39

Byron Thompson & Company, Inc., of Jacksonville and Orlando, and Medical Supply Company of Miami will exhibit the latest items in instrument specialties, featuring the Birtcher Blendtome, which is the latest portable instrument with tube and spark gap combined. Visits to the booth will be appreciated.

CAMEL CIGARETTES—25

Camel Cigarettes will feature color slides of background data from their newest research. After weekly examinations of the throats of hundreds of men and women smoking Camel Cigarettes exclusively for thirty days, throat specialists reported "Not one single case of throat irritation due to smoking Camels."

CAMERON SURGICAL SPECIALTY COMPANY—30

See the new Rado-Gap Cauterodynes with Spark-Gap, Radio-Frequency and Blended Circuits, the Cauteradio and other Units and Accessories for all phases of Electro-Surgery, Electro - Cauterization, Electro - Coagulation, Desiccation and Fulguration; Electro-Diagnostic Lamp and Instrument Outfits; the new stainless steel Boros Flexible Esophagoscope and Broncho-Esophago-Laryngoscopic Sets; Coagulair Sigmoidoscope; Tele-Vaginalite; Mirrolite and other Headlites; Binocular Loupes; Illuminated Specula, Endoscopes, Retractors and other Instruments for all types of Diagnosis, Treatment and Surgery.

CIBA PHARMACEUTICAL PRODUCTS, INC.—21

The Ciba exhibit of "Economical Hormone Therapy" will feature Metandren Linguets, the most potent oral androgen in tablets designed for absorption through sublingual mucosa, Lutocylol Linguets, orally effective progestogen especially designed for sublingual absorption, and Eticylol, the most potent oral estrogen. Representatives in attendance will gladly furnish literature and answer questions about these and other Ciba products.

THE COCA-COLA COMPANY—8

Coca-Cola will be served to members and their guests with the compliments of the Coca-Cola Company.

LEDERLE LABORATORIES—1

Physicians are cordially invited to visit the booth of Lederle Laboratories where representatives are prepared to provide the latest information on Lederle products.

ELI LILLY AND COMPANY—22

The Lilly medical service representative cordially invites physicians to visit the Lilly exhibit. Many new therapeutic developments will be featured and literature on these products will be available. Lilly medical service representatives are to be in attendance to aid visiting physicians in every way possible.

J. B. LIPPINCOTT COMPANY—19

J. B. Lippincott Company presents an interesting and active exhibit of professional publishing. With the "pulse of practice" centering in an advisory editorial board of active clinicians who constantly review the field, current and coming trends in medicine and surgery are known continually. On the studied recommendations of these medical leaders, Lippincott Selected Professional Books are undertaken.

M & R DIETETIC LABORATORIES, INC.—2

The M & R Dietetic Laboratories, Inc., will display Similac, a food for infants. Representatives will appreciate the opportunity to discuss the merit and suggested application for both the normal and special feeding cases.

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MEAD JOHNSON & COMPANY—33

Amigen and Protolysate will be on display at the Mead Johnson exhibit. Mead Johnson has pioneered the amino acid field commercially; the products have been described in more than four hundred articles in the medical literature. Trained representatives will be at the Mead exhibit to discuss details of the new amino acid products. Shown also will be Dextri-Maltose, Pablum, Pabena, Oleum Percomorphum and the other Mead Products used in Infant Nutrition. Protenum, a new high protein product, and also Lonalac for low sodium diets will be displayed.

THE NATIONAL DRUG COMPANY—15

Resinat, completely nontoxic, anion exchange resin antacid and pepsin inhibitor, and Protinal Powder, delicious, micro pulverized, whole protein carbohydrate, will be the featured products. Samples and literature will be available. Trained representatives will be on hand to answer inquiries concerning any of National's vast array of pharmaceutical, biological and biochemical preparations.

PARKE, DAVIS & COMPANY—20

Members of the Parke, Davis & Company Medical Service Staff will be on hand at the commercial exhibit for consultation and general discussion of the Products classified in our Pharmaceutic, Antibiotic, and Biologic Lines. Important Specialties, such as Penicillin S-R, Benadryl, Vitamin Products, Hypnotics, Antibiotics, Etamon, Oxycel, Thrombin Topical, Influenza Virus Vaccine, and other Biologics will be featured. Physicians are cordially invited to visit the booth with the assurance that the interest will be appreciated.

PET MILK COMPANY—17

Specially trained representatives will be in attendance to discuss the use of Pet Milk in infant feeding and to present many services that are time savers for busy physicians. Miniature Pet Milk cans will be given to visitors at the exhibit.

PHILIP MORRIS & CO., LTD., INC.—4

Philip Morris & Company will demonstrate the method by which it was found that Philip Morris Cigarettes, in which diethlyene glycol is used as the hygroscopic agent, are less irritating than other cigarettes. Their representative will be happy to discuss researches on this subject and problems on the physiological effects of smoking.

PICKER X-RAY CORPORATION—6

Picker X-Ray Corporation will display the Comet, a versatile utility combination fluoroscopic and radiographic x-ray unit. It is shown as a 100 MA Model. However, it can also be obtained as a 60 MA or 15 MA unit. A sturdy auxiliary steel table equipped with a bucky diaphragm is available optionally for horizontal radiography. There will also be on display the new improved Gynograph for uterotubal insufflation.

SCHERING CORPORATION—31

Among the new pharmaceutical and hormone preparations developed in the Schering research laboratories, Micropellets Progynon will be featured. This new potent form of the female sex hormone, alpha estradiol, provides maximum results at minimum cost to the patient. Combisul and Combisul Liquid, the triple sulfonamide combinations which eliminate the dangers of sulfonamide renal damage, will also be presented. Trimeton, the outstanding antihistaminic, will highlight the exhibit. Schering Professional Service Representatives will be happy to answer inquiries concerning Schering's new products as well as their other hormone, x-ray diagnostic, chemotherapeutic, and pharmaceutical specialties.

G. D. SEARLE & CO.—13

At the Searle booth representatives will be happy to answer any questions regarding Searle Products of Research. Featured will be Ruphyllin, for abnormal capillary fragility; Hydryllin, new and effective antihistaminic; as well as such time proven products as Searle Aminophyllin in all dosage forms, Metamucil, Ketochol, Floraquin, Kiophyllin, Diodoquin, Pavatrine and Pavatrine with Phenobarbital.

SHARP & DOHME, INC.—14

Visitors are cordially invited to visit the Sharp & Dohme exhibit. Stable, portable 'Lyovac' Normal Human Plasma irradiated to destroy not only bacteria but also the viral contaminants that might cause homologous serum hepatitis merits attention. Unusual Specialties including the popular sulfonamide and antibiotic drugs also will be of major interest. Courteous attendants will be pleased to answer inquiries.

SPENCER, INCORPORATED—10

On display will be Spencer Individually Designed Supports for abdomen, back and breasts. Physicians are particularly invited to investigate the Spencer Abdominal Spring Pad; the Spencer Mastectomy Breast Support with Breast Forms; and such special orthopedic features as our Outside Pelvic Binder, removable rigid steels with molding tools, and pivoting shoulder straps. Also on display will be the Spencer Blood Pressure Sleeve, a new, convenient, accurate, time saving item for the busy physician.

U. S. VITAMIN CORP.—38

Enlarged color photographs will be shown of common oral lesions of nutritional deficiencies including glossitis, cheilosis, gingivitis and others, as well as improvement following administration of complete vitamin therapy. Professional samples and literature will be available on Vi-Syneral, Vi-Syneral Vitamin Drops, Poly-B, Vi-Litron, Hypervitam, Lipo-Heplex, Putin-Rutascorb, Methischol, Tri-Sulfanyl, Vi-Syneral Injectable and others.

WALKER VITAMIN PRODUCTS, INC.—32

Protoplex will be featured at the Walker exhibit. This new product combines the proteins from casein, lactalbumin, yeast and liver in delicious cereal-like granules. Precalcin, the "dry-fill" capsules of vitamins and minerals for prenatal use, will also be shown along with the Hyvanol-Amvitol products for nerve deafness. Other important therapeutic agents will also he on display.

WINTHROP-STEARNS, INC.—7

Winthrop-Stearns, Inc., New York, extends a cordial invitation to visit its booth where representatives will be no hand to discuss the latest pharmaceutical preparations made by this firm. Featured will be Isuprel, new, more efficient and convenient bronchodilator; Aralen, the modern colorless antimalarial specific; Neocurtasal, sodium-free seasoning agent.

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Not infrequently babies resist the first feeding of egg. The mixing of Pablum or Pabena (Mead Johnson & Company) with soft-boiled egg when this important food is offered to the infant for the first time may overcome this initial resistance. After the egg is opened and the contents are placed in a cup, one to three level tablespoons of Pablum or Pabena may be added, depending on the consistency desired. This makes a uniform mixture.

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From where I sit
by Joe Marsh

Yes, Sir, Insomnia's Contagious!

Bud Swanson had trouble sleeping nights last summer. Tried to get over it by turning up the radio full blast and started an epidemic of insomnia all down the block!

Folks finally dropped a hint to Bud that he close the windows or turn the radio a little lower. Bud did—and that was the quickest cure for *other* folks' insomnia I've ever heard of!

Not that any of us object to the radio, or swing bands, or anything else that helps another person relax of an evening. (Myself, I like a glass of beer with a bit of cheese before I go to bed. I can't speak for you.)

From where I sit, good neighborliness means nothing more than simply respecting the other person's tastes and rights—without forcing your own tastes or opinions down his throat. And that goes for Bud's radio, my glass of beer, or whatever temperate pleasure *you* happen to enjoy

Joe Marsh

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BOOKS RECEIVED

THE CASE AGAINST SOCIALIZED MEDICINE, A CONSTRUCTIVE ANALYSIS OF THE ATTEMPT TO COLLECTIVIZE AMERICAN MEDICINE. By Lawrence Sullivan. Price, $1.50. Pp. 53. Washington: The Statesman Press, 1948.

Straightforward, clear, succinct, this little book presents in two minute chapters the historical background of socialized medicine, as now advocated in the United States. The author is a veteran Washington newspaperman and radio reporter, who knows intimately the hidden mechanics of bureaucratic controls.

The story is told principally from the sworn testimony of witnesses before the Committees of the House and Senate. Every American interested in the fight for freedom and ordered liberty under law will find the narrative of the Wagner-Murray-Dingell campaign exciting reading.

Too, there is the story of socialized medicine in other lands, weighed without partisanship. The reader learns what happens when people lose the right to select their own doctor. He discovers how medical education curdles under the last of executive order control. He also finds out what happens to the health of a nation when village doctors are selected like postmasters.

This book deserves wide circulation, for its fund of information and brevity and clarity of presentation make it a ready reference for all, particularly the busy physician. It is dedicated "to the men and women of American Medicine, who are too busy in good works to answer the slanderous darts of the bureaucrats."

PREMATURE INFANTS, A MANUAL FOR PHYSICIANS. By Ethel C. Dunham, M.D. Price, $1.25. Pp. 401. Washington: Federal Security Agency, Social Security Administration, Children's Bureau, 1948.

This comprehensive guide for the general practitioner and others professionally interested brings together the available information in the literature on premature infants. The single greatest cause of infant mortality is premature birth, which accounts for one half of all infant deaths in the first month of life. It is estimated that at least 1 in 20 babies is born prematurely.

Part I deals with general considerations—definition of and criteria for prematurity; incidence, causes and prevention of premature birth; death rates and causes of death; and the growth and development of premature infants. Part II deals with clinical considerations—the physiologic handicaps of premature infants; the general problems of their care; and the congenital and acquired conditions that tend to affect them adversely. Such subjects as resuscitation, incubator care, nutritional requirements, congenital malformations and infection are discussed.

This book may be purchased from the Superintendent of Documents, Government Printing Office, Washington, D. C.

PHYSICIAN'S HANDBOOK. By John Warkentin, M.D., and Jack D. Lange, M.D. Ed. 5. Price, $2.00. Pp. 294. Palo Alto, Calif.: University Medical Publishers, 1948.

This Handbook summarizes tersely, clearly and comprehensively diagnostic procedures and factual data which the physician needs to have quickly available. In this edition the scope of the work has been extended so as to make it a serviceable pocket-reference for many types of medical practice. An effort has been made to include a relatively complete laboratory manual, the common clinical tests, and such other factual information as is more readily forgotten.

Emphasis on clinical factors, such as the significance of abnormal laboratory test findings, is noteworthy in this revision, particularly in the sections on the comatose patient; urine, blood, and liver tests; the hormones; and diagnosis of poisoning. An autopsy outline and treatment of acute poisonings and alcoholic intoxication have been added. Some simplifications of older tests are also included, such as the "newspaper test" for urine sulfonamides.



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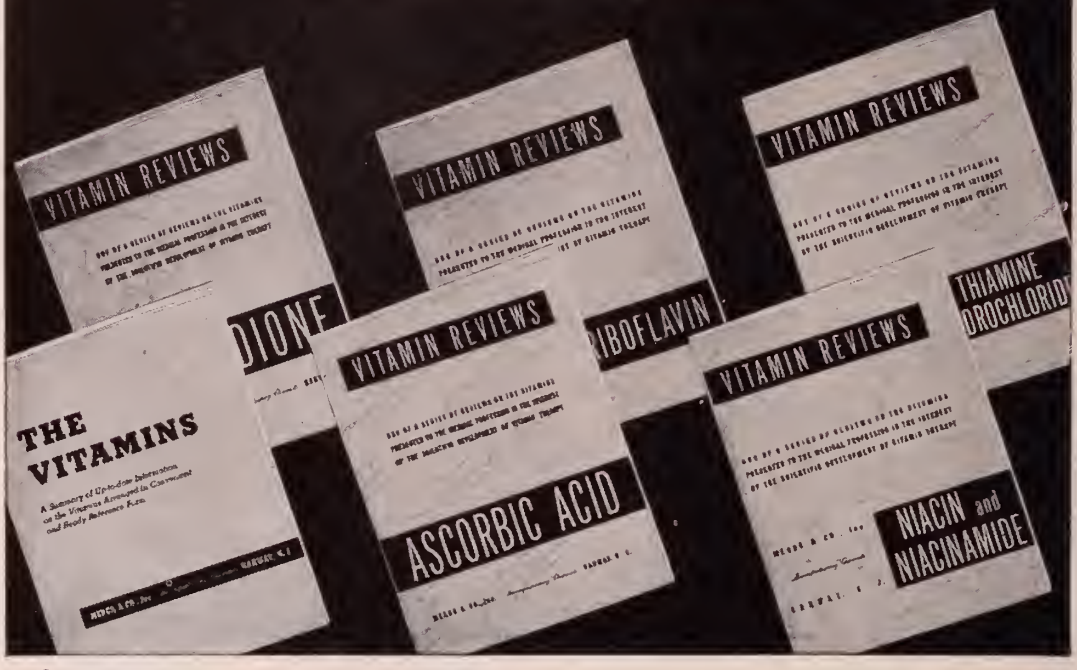
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- **Distribution in foods.**
- **Methods of administration.**
- **Clinical use in specific conditions.**

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FOR AMERICANS ONLY. By Samuel B. Pettengill and Paul C. Bartholomew, Ph.D. Pp. 192. New York: America's Future, Inc., 1944.

Four years prior to the publication of this book, "Smoke-Screen" by former Congressman Pettengill was published to point out the beginnings of New Deal fascism. "For Americans Only" picks up where "Smoke-Screen" left off. It shows America's progress along the road into national socialism under New Deal leadership and gives a vivid and substantiated picture of its bureaucrats fastening on the nation's economic life permanent controls similar to those Hitler and the Nazi party fastened on Germany. It makes a strong plea for upholding the basic principles which have made America.

SMOKE-SCREEN. By Samuel B. Pettengill. Price, $1.00. Pp. 126. New York: Southern Publishers, Inc., 1940.

A special edition of this book has been printed for and is distributed by America's Future, Inc., a nonprofit corporation of New York City, in the belief that the Pettengill books of some years ago were prophetic and are in retrospect more and more worth reading.

"Smoke-Screen" was written nearly a decade ago to demonstrate that this country is moving toward National Socialism, and that it should, instead, be moving away from it. After eight years in the Congress of the United States, the author was convinced that the American people have not chosen that course and will not freely and deliberately make that decision. He contended that the decision is being made for them behind the smoke-screen of an unguaranteed political promise of the more abundant life.

The single vital issue is set forth as clearly for today as yesterday—"whether the general welfare we all seek can be more certainly attained under free enterprise or collectivism; under the Constitution of the United States which makes the state the servant of the people, or under Marxism, which makes the people the slaves of the State."

ANESTHESIA, PRINCIPLES AND PRACTICE. By Alice Maude Hunt, R.N. Price, $2.60. Pp. 148. New York: G. P. Putnam's Sons, 1949.

This book, written by a nurse for nurses, should prove particularly useful as a ready reference for members of the nursing profession now engaged as anesthetists and also valuable as a concise text for students of the subject. It is the outgrowth of many years of teaching experience of the author, who is associate professor of anesthesia emeritus, Yale School of Medicine. She focuses attention on the patient, not the surgeon, as rightly being in the center of the picture and constantly reminds the nurse of the important role in which she is cast.

Modern methods and technics, together with their modifications, are set forth in a thoroughgoing manner, The use of standard equipment is carefully explained.

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Surgical Anatomy & Clinical Surgery, Two Weeks, starting March 21, April 18, May 16.
Surgery of Colon & Rectum, One Week, starting March 7, April 11.
Esophageal Surgery, One Week, starting June 13.
Thoracic Surgery, One Week, starting June 20.
Breast & Thyroid Surgery, One Week, starting June 27.
GYNECOLOGY—Intensive Course, Two Weeks, starting March 21, April 18, June 20.
Vaginal Approach to Pelvic Surgery, One Week, starting April 4, May 16.
OBSTETRICS—Intensive Course, Two Weeks, starting March 7, April 4.
MEDICINE—Intensive Course, Two Weeks, starting April 4.
Electrocardiography & Heart Disease, Four Weeks, starting March 16.
Personal Course in Gastroscopy, Two Weeks, starting March 7, May 16.
Diagnosis & Treatment of Congenital Malformation of Heart, Two Weeks, starting June 13.
PEDIATRICS—Intensive Course, Two Weeks, starting April 4.
DERMATOLOGY—Formal Course, Two Weeks, starting May 2.
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SCHEDULE OF MEETINGS

ORGANIZATION	PRESIDENT	SECRETARY	ANNUAL MEETING
lorida Medical Association	Joseph S. Stewart, Miami	Robert B. McIver, Jacksonville	Belleair, Apr. 10-13, 1949
lorida Medical Districts	Herman Watson, Lakeland	Council Chairman	
A-Northwest	Irby H. Black, Live Oak	William P. Hixon, Pensacola	Quincy, 1949
B-Northeast	Rabun H. Williams, Eustis	Charles C. Grace, St. Augustine	Palatka, 1949
C-Southwest	John M. Butcher, Sarasota	H. Quillian Jones, Ft. Myers	Sebring, 1949
D-Southeast	Russell B. Carson, Ft. Lauderdale	Erasmus B. Hardee, Vero Beach	Ft. Lauderdale, 1949
lorida Specialty Societies			
Derm. and Syph., Soc. of	A. Buist Litterer, Miami	Wesley W. Wilson, Tampa	Belleair, April 10, 1949
Genl. Practice of Med.	M. Crego Smith, Clearwater	Walter E. Murphree, Gainesville	Belleair, April 10, 1949
Health Officers' Society	Roger F. Sondag, Jacksonville	Lorenzo L. Parks, Jacksonville	Belleair, April 10, 1949
Industrial & Railway Surgeons	F. Hardy Bowen, Jacksonville	J. H. Mitchell, Jacksonville	Belleair, April 10, 1949
Neurology & Psychiatry	James G. Lyerly, Jacksonville	William H. McCullagh, Jacksonvill	Belleair, April 10, 1949
Ob. and Gynec. Society	Chas. J. Collins, Orlando	Dorothy D. Brame, Orlando	Belleair, April 10, 1949
Ophthal. & Otol., Soc. of	Bascom H. Palmer, Miami	W. Jerome Knauer, Jacksonville	Belleair, April 10, 1949
Orthopedic Society	Charles B. Mabry, Jacksonville	Eugene L. Jewett, Orlando	Belleair, April 10, 1949
Pathological Society	James N. Patterson, Tampa	Gretchen V. Squires, Pensacola	Belleair, April 10, 1949
Pediatric Association, State	Edgar W. Stephens, W. P. Beach	Hugh A. Carithers, Jacksonville	Belleair, April 10, 1949
Proctologic Society	Dean W. Hart, St. Petersburg	Frederick E. Farrer, Miami	Belleair, April 10, 1949
Radiological Society	James F. Pitman, Lake City	Floyd K. Hurt, Jacksonville	Belleair, April 9-10, 1949
Urological Society	Milton M. Coplan, Miami	Russell B. Carson, Ft. Lauderdale	Belleair, April 10, 1949
lorida—			
Academy, Public Medicine	Robert T. Spicer, Miami	Shaler Richardson, Jacksonville	Belleair, April 13, 1949
Basic Science Exam. Board	Paul A. Vestal, Winter Park	M. W. Emmel, D.V.M., Gainesville	Gainesville, June 11, '49
Dental Society, State	T. C. Henslee, D.D.S., Miami	Larry Schulstad, D.D.S., Bradenton	
Hospital Association	Mr. H. Louie Wilson, Gainesville	Mr. H. A. Schroder, Jacksonville	November, 1949
Hospital Service Corporation	Mr. W. E. Arnold, Jacksonville	Mr. H. A. Schroder, Jacksonville	
Medical Examining Board	Homer L. Pearson, Jr., Miami	Frank D. Gray, Orlando	Jacksonville, June 26-28, 1949
Medical Postgraduate Course	Turner Z. Cason, Jacksonville	Chairman	
Medical Service Corporation	Leigh F. Robinson, Ft. Lauderdale	Herbert E. White, St. Augustine	Belleair, April, 1949
Nurses Association, State	Mrs. Elsie M. Airheart, Tampa	Miss Helen Shearston, Miami	Sarasota, October, '49
Pharmaceutical Association, State	Mr. D. M. Weaver, Miami	Mr. R. Q. Richards, Ft. Myers	Miami, May 17-19, '49
Public Health Association	Turner E. Cato, Miami	Mr. Fred B. Ragland, Jacksonville	West Palm Beach, Oct. 6-8, '49
Tuberculosis & Health Assn.	Judge Ernest E. Mason, Pensacola	Mr. Walton MacJordan, Orlando	May, 1949
Woman's Auxiliary	Mrs. L. E. Parmley, Winter Haven	Mrs. C. R. Morgan, Jr., Miami	Belleair, Apr. 10-13, 1949
merican Medical Association	R. L. Sensenich, South Bend, Ind.	Geo. F. Lull, Chicago	Atlantic City, June 6-10, 1949
outhern Medical Association	E. L. Henderson, Louisville, Ky.	C. P. Loranz, Birmingham	Cincinnati, Nov. 14-17, '49
labama Medical Association	J. Paul Jones, Camden, Ala.	Douglas L. Cannon, Montgomery	Montgomery, Ala., Apr. 19-21, 1949
eorgia, Medical Assn. of	Edgar Hill Greene, Atlanta	Edgar D. Shanks, Atlanta	Savannah, Ga., May 10-13, '49
E. Hospital Conference	Mr. Burton M. Battle, New Orleans	Mr. R. F. Whitaker, Atlanta	Biloxi, Miss., April 27-29, '49
outheastern Allergy Assn.	Oscar Swineford, Charlottesville, Va.	Kath. B. MacInnis, Columbia, S. C	Columbia, S. C., 1950
outheastern, Am. College Phys.	Webster Merritt, Jacksonville	Florida Program Chairman	
outheastern, Am. Urological Assn.	Harold P. McDonald, Atlanta	Russell B. Carson, Ft. Lauderdale	Boca Raton, March 21-24, '49
outheastern Surgical Congress	Gilbert Douglas, Birmingham, Ala.	B. T. Beasley, Atlanta	Biloxi, Miss., May 23-26, '49

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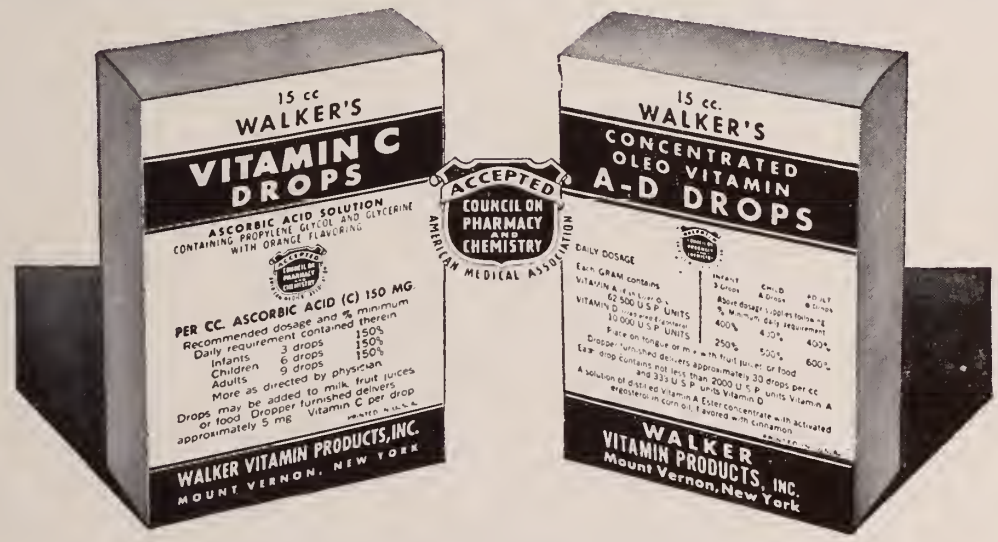
	SOCIETY	PRESIDENT	SECRETARY	MEETING DATE	MEMBERS Hon.	MEMBERS Regular	COUNCILOR
A	Bay	Martle F. Parker, M.D. Panama City	Russell T. Stewart, M.D. 224 East 4th St. Panama City		0	15	
	Escambia *Santa Rosa*	Alvyn W. White, M.D. 24 W. Chase St. Pensacola	Arthur J. Butt, Jr., M.D. 1101 N. Palafox St. Pensacola	2nd Tuesday 8:00 P.M.	1	60	
	Franklin-Gulf	Albert L. Ward, M.D. Port St. Joe	Donald H. Anderson, M.D. Port St. Joe	3rd Tuesday Odd Months	0	6	A-1-50 William P. Hixon, M.D. Pensacola
	Jackson *Calhoun*	Daniel A. McKinnon, M.D. Marianna	Francis M. Watson, M.D. 120 Deering St. Marianna	3rd Thursday 7:30 P.M.	0	16	
	Walton-Okaloosa	Arthur G. Williams, Sr. Lakewood	Ralph B. Spires, M.D. DeFuniak Springs	3rd Thursday 8:00 P.M.	0	13	
	Washington-Holmes	N. J. Dawkins, M.D. Vernon	B. W. Dalton, M.D. Chipley		0	5	
B	Columbia *Baker-Hamilton*	Robert B. Harkness, M.D. 525 E. Duval St. Lake City	Thomas H. Bates, M.D. 27 W. Madison St. Lake City	1st Monday 7:30 P.M.	0	14	
	Leon-Gadsden-Liberty-Wakulla-Jefferson	Merritt R. Clements, M.D. 1232 N. Monroe Street Tallahassee	Edward C. Love, Jr., M.D. Masonic Temple Bldg. Quincy	Quarterly 7:30 P.M.	1	46	A-2-49 Irby H. Black, M.D. Live Oak
	Madison-Suwannee	A. Franklin Harrison, M.D. Madison	Irby H. Black, M.D. 918 W. Howard St. Live Oak		1	9	
	Taylor *Dixie-Lafayette*	Walter J. Baker, M.D. Foley	Ralph J. Greene, M.D. Perry	Last Friday 8:00 P.M.	0	4	191
	Alachua *Bradford, Gilchrist Union*	Alva T. Cobb, Jr., M.D. 505 W. University Ave. Gainesville	F. Emory Bell, M.D. Box 400 Gainesville	2nd Tuesday 8:00 P.M.	1	34	
	Duval *Clay*	Raymond R. Killinger, M.D. 450 St. James Bldg. Jacksonville	Janet G. Leser, M.D. 1016 LaSalle St. Jacksonville	1st Tuesday 8:15 P.M.	2	240	
	Marion *Levy*	Robert E. Thompson, M.D. Holder Bldg. Ocala	Bertrand F. Drake, M.D. Professional Bldg. Ocala	3rd Wednesday 12:30 P.M.	2	27	B-3-50 Charles C. Grace, M.D. St. Augustine
	Nassau	David G. Humphreys, M.D. Fernandina	John W. McClanc, M.D. Fernandina	Last Friday 8:00 P.M.	1	8	
	Putnam	Grover C. Collins, M.D. 502 Reid St. Palatka	Lawrence G. Hebel, M.D. 119 N. 4th St. Palatka	2nd Tuesday 6:00 P.M.	0	10	
	St. Johns	Reddin Britt, M.D. Box 565 St. Augustine	S. Raymond Cafaro, M.D. Exchange Bank Bldg. St. Augustine	3rd Tuesday 8:30 P.M.	1	14	
C	Brevard	Charles E. Russell, M.D. 16 Magnolia St. Cocoa	Theodore J. Kaminski, M.D. Box 576 Melbourne	2nd Tuesday	0	14	
	Lake *Sumter*	Leroy H. Oetjen, M.D. Leesburg	William L. Musser, M.D. Mount Dora	1st Wednesday 7:30 P.M.	1	23	B-4-49 Rabun H. Williams, M.D. Eustis
	Orange *Osceola*	Robert P. Henderson, M.D. 544 N. Orange Ave. Orlando	Gerald W. Jones, M.D. American Bldg. Orlando	3rd Wednesday 8:00 P.M.	4	130	
	Seminole	Leonard I. Munson, M.D. Touchton Bldg. Sanford	Frank L. Quillman, M.D. Box 158 Sanford	2nd Tuesday 5:30 P.M.	0	11	
	Volusia *Flagler*	Joseph H. Rutter, M.D. Rt. 1, Box 303-A Daytona Beach	Robert L. Miller, M.D. 258½ S. Beach St. Daytona Beach	2nd Tuesday 7:30 P.M.	2	51	562
	Hillsborough	William M. Rowlett, M.D. Box 786 Tampa	Herschel G. Cole, M.D. 315 Wallace S. Bldg. Tampa	1st Tuesday 8:00 P.M.	0	148	
	Manatee	Willis W. Harris, M.D. First National Bank Bldg. Bradenton	Joseph A. Gibson, M.D. Palmetto	3rd Tuesday 7:00 P.M.	0	18	C-5-49 John M. Butcher, M.D. Sarasota
	Pasco-Hernando-Citrus	Donald G. Bradshaw, M.D. Zephyrhills	W. Wardlaw Jones, M.D. Box 247 Dade City	2nd Thursday 7:00 P.M.	0	14	
	Pinellas	Francis H. Langley 190 18th Ave. St. Petersburg	Whitman C. McConnell, M.D. 313 First Federal Bldg. St. Petersburg	1st Monday 6:30 P.M.	7	148	
D	Sarasota	Millard B. White, M.D. 151 S. Pineapple Ave. Sarasota	Talmadge S. Thompson, M.D. Box 224 Venice	2nd Tuesday 8:30 P.M.	1	23	
	DeSoto-Hardee-Highlands-Charlotte-Glades	John A. Simmons, M.D. Box 430 Arcadia	Charles H. Kirkpatrick, M.D. Box 389 Arcadia	2nd Tuesday 8:00 P.M.	0	25	C-6-50 H. Quillian Jones, M.D. Ft. Myers
	Lee *Collier, Hendry*	Curtis R. House, M.D. 2 Darling Bldg. Ft. Myers	Joseph L. Selden, Jr., M.D. 416 Richards Bldg. Ft. Myers	3rd Monday 7:30 P.M.	0	23	
	Polk	Byron Y. Pennington, M.D. Lake Wales	John W. Vaughn, M.D. Box 475 Lakeland	2nd Wednesday 7:00 P.M.	1	74	482
	Indian River	John P. Gifford, M.D. Vero Beach	William L. Fitts, 3rd, M.D. Vero Beach Arcade Vero Beach	2nd Tuesday 8:00 P.M.	0	8	
	Palm Beach	William E. Bippus, M.D. Comeau Bldg. West Palm Beach	Cecil M. Peek, M.D. 535 S. Flagler Dr. West Palm Beach	3rd Monday 8:00 P.M.	1	92	D-7-50 Erasmus B. Hardee, M.D. Vero Beach
	St. Lucie-Okeechobee-Martin	Adrian M. Sample, M.D. Box 897 Ft. Pierce	Jerome A. Megna, M.D. 706 S. 6th St. Ft. Pierce	3rd Thursday 8:00 P.M.	0	13	
	Broward	Paul G. Shell, M.D. 420 Sweet Bldg. Ft. Lauderdale	Scottie J. Wilson, M.D. 309 Blount Bldg. Ft. Lauderdale	4th Tuesday 8:00 P.M.	4	61	D-8-49 Russell B. Carson, M.D. Ft. Lauderdale
	Dade	John D. Milton, M.D. 1105 Huntington Bldg. Miami	Benjamin G. Oren, M.D. 628 duPont Bldg. Miami	1st Tuesday 8:30 P.M.	6	483	
	Monroe	James B. Parramore, M.D. 523 Whitehead St. Key West	Wallace H. Mitchell, M.D. Key West	2nd Thursday 8:00 P.M.	0	13	681

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*Magladery, J.: Therapeutic Conference, The Treatment of Epilepsy. Bull. Johns Hopkins Hosp., 82:609, (June) 1948.

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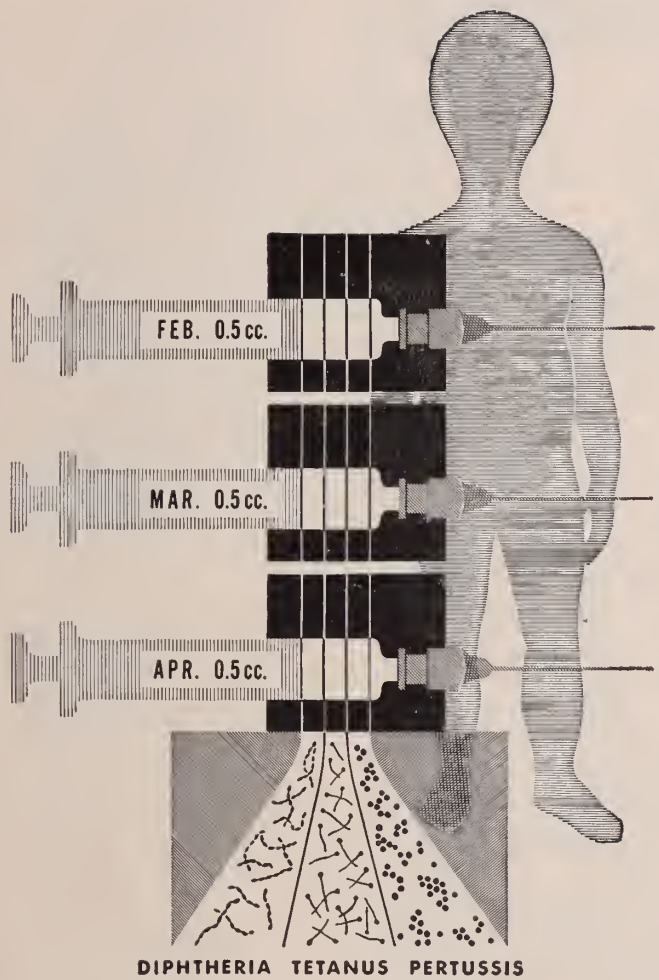
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This Journal is not responsible for the opinions and statements of its contributors.

Published monthly at Jacksonville, Florida. Price $5.00 a year; single numbers, 50 cents. Address Journal of the Florida Medical Association, P. O. Box 1018 (Fla. Theater Bldg.), Jacksonville 1, Fla. Telephone 6-1571. Accepted for mailing at special rate of postage provided for in Section 1103, Act of Congress of October 3, 1917; authorized October 16, 1918. Entered as second-class matter under Act of Congress of March 3, 1879, at the post office at Jacksonville, Florida, October 23, 1924.



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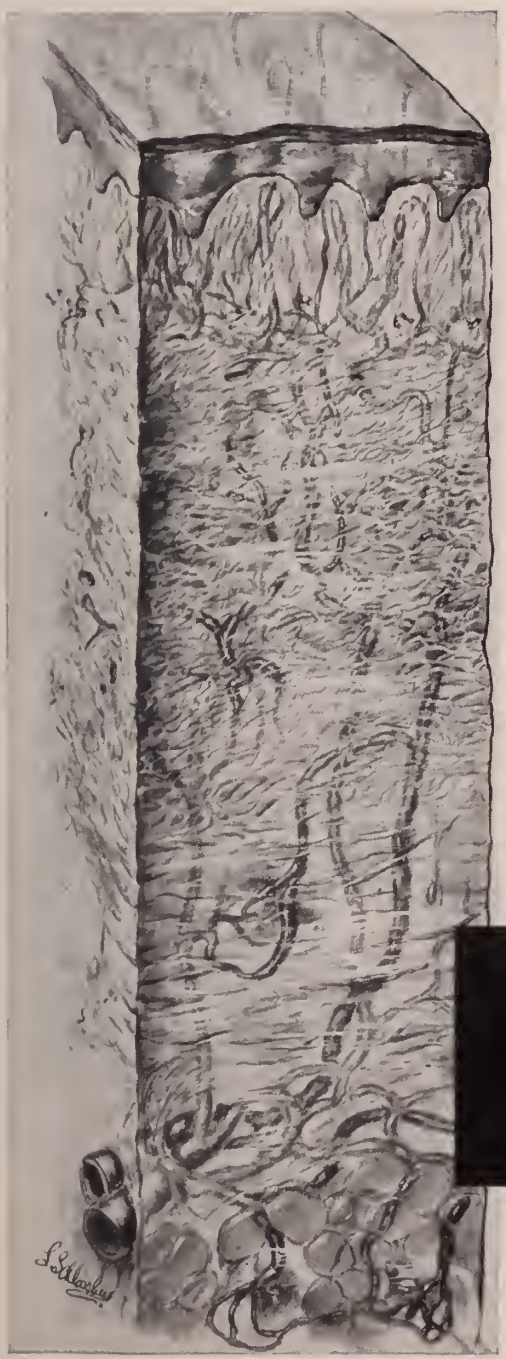
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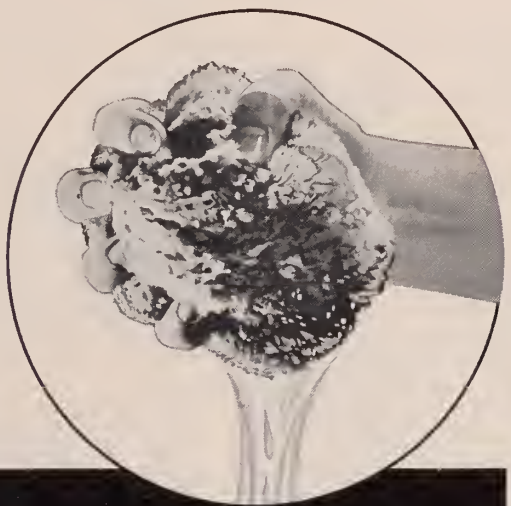
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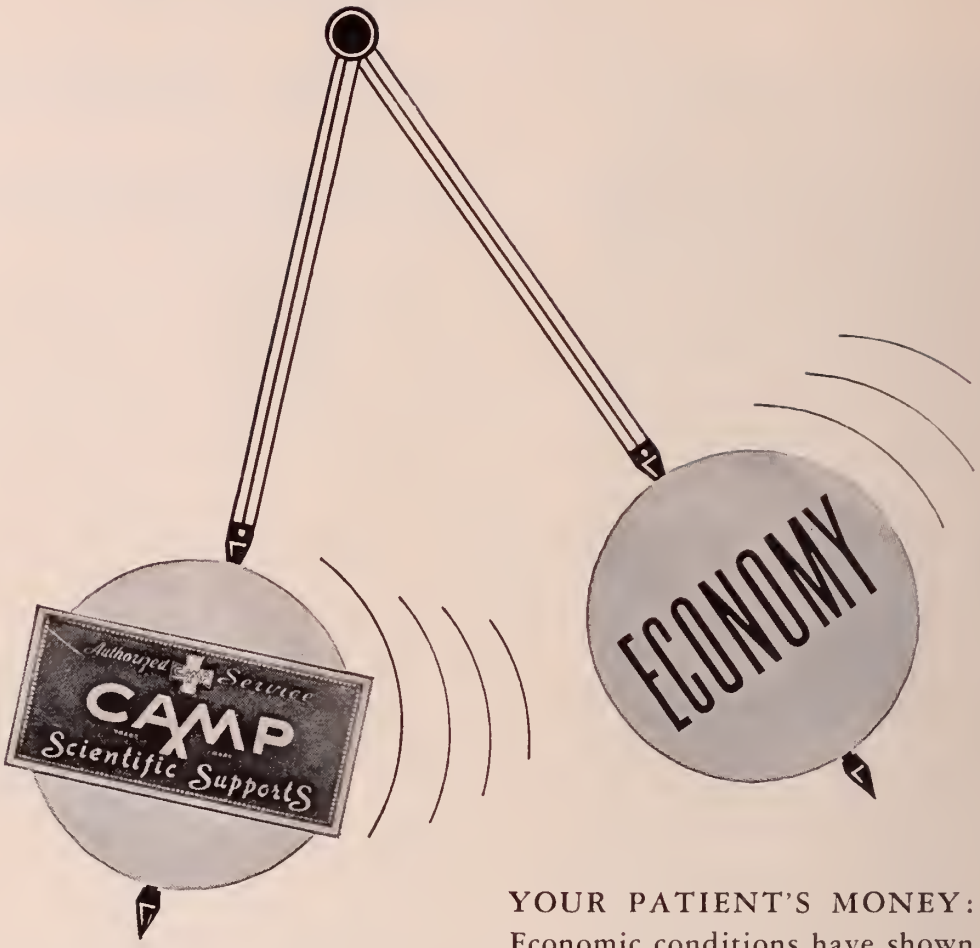
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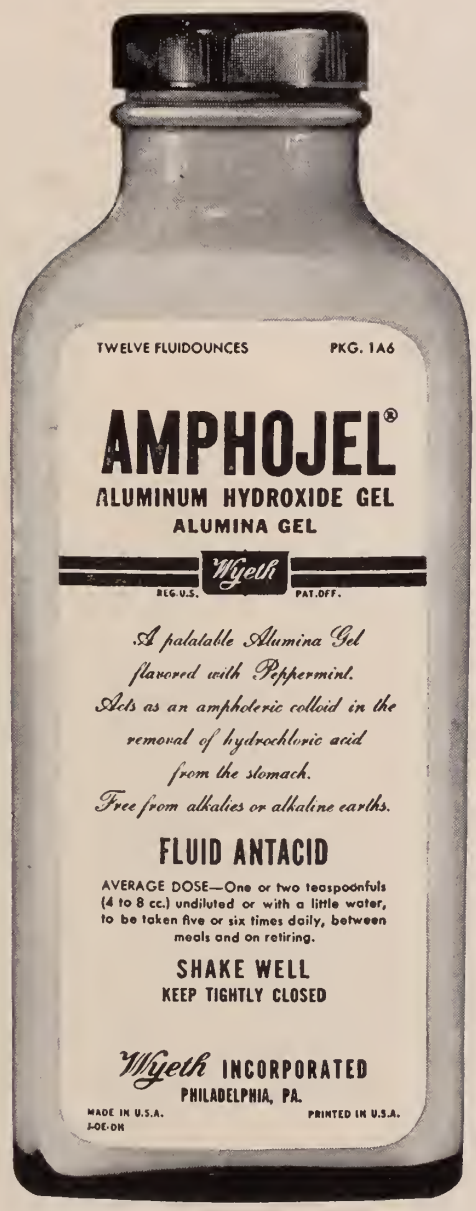
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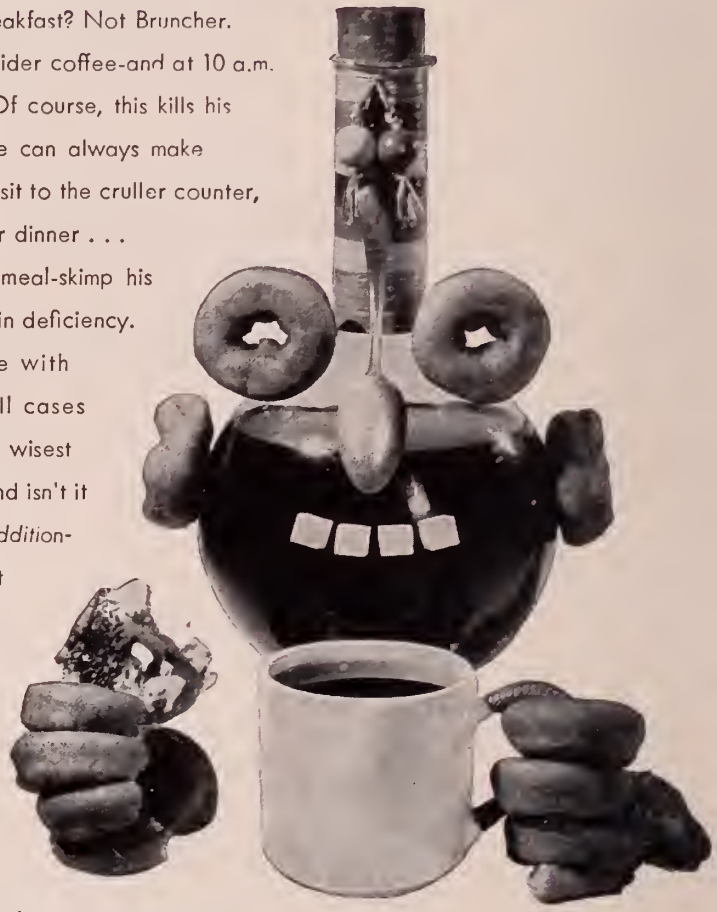


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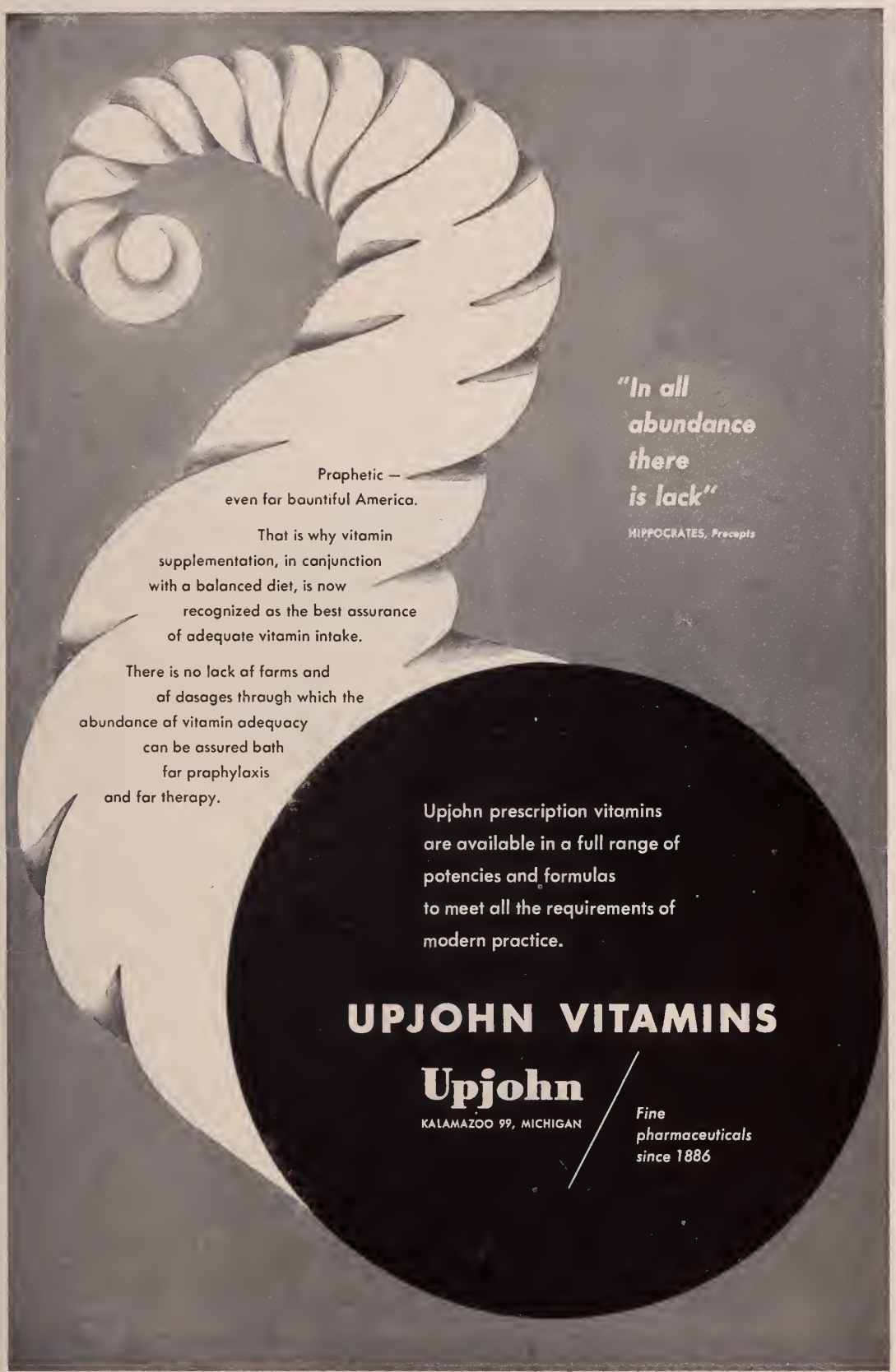
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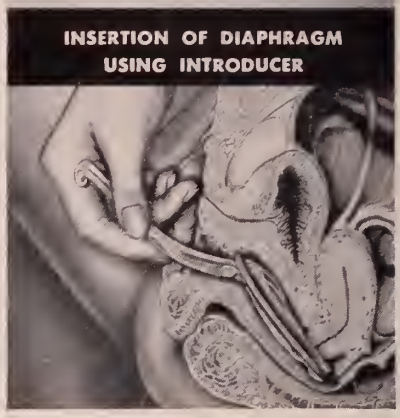
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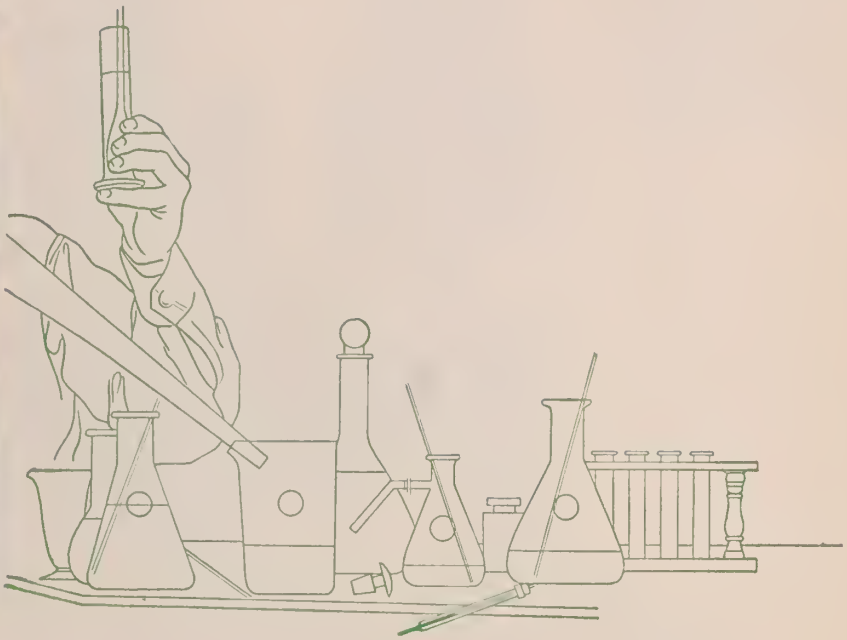
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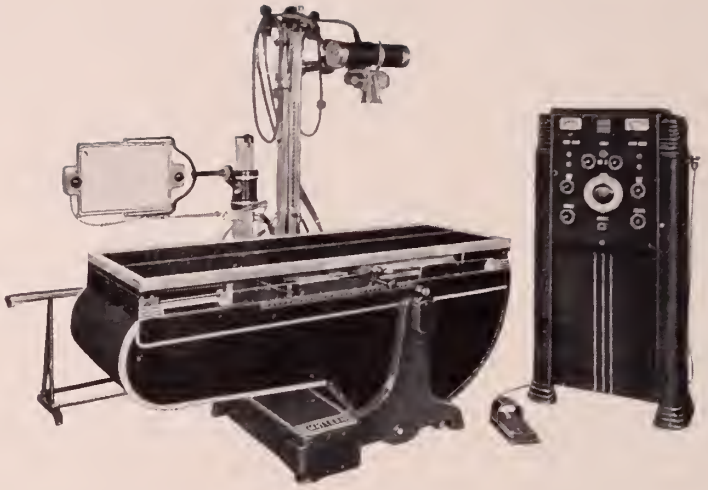
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THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION
PUBLISHED MONTHLY
Volume XXXV | Jacksonville, Florida, April, 1949 | No. 10

Laryngofissure and Laryngectomy in Treatment of Intrinsic Carcinoma of the Larynx

J. Brown Farrior, M.D.
TAMPA

Introduction

Hoarseness is, fortunately, a very early sign of intrinsic carcinoma of the larynx. If such a cancer is removed at this early period, the possibility of a permanent cure is excellent. Some statistics report as high as 95 per cent five year cures. Even relatively late in the course of the disease, surgical removal will produce a five year cure in a majority of cases, as these lesions are usually slow growing and tend to remain localized within the cartilaginous box of the larynx. Although intrinsic carcinoma of the larynx is a curable disease, the statistics of the Florida State Board of Health reveal that, during the last seven years, there have been 195 reported deaths from cancer of the larynx. This relatively high number of deaths has occurred for three reasons; first, the failure of the patient to recognize the significance of hoarseness as a possible sign of cancer; secondly, the failure of the physician to recognize the significance of hoarseness as a sign of cancer; and, thirdly, the willingness of the patient and the physician to accept cancer as an incurable disease.

Any patient with hoarseness persisting for more than two weeks should have an indirect laryngoscopic examination, for this simple office procedure will exclude or indicate the possibility of a carcinoma. Fortunately, patients with hoarseness will consult a physician within the first few weeks. If a laryngoscopic examination is done and the carcinoma discovered, there will result a high instance of cures. If, on the other hand, the patient is reassured and given home remedies, the carcinoma will continue to grow until, at the time of the patient's second examination, it has often become incurable.

Surgery Versus Radiation Therapy

The treatment of choice for intrinsic carcinoma of the larynx is surgical removal.

It was once hoped that fractionated radiation therapy would cure intrinsic carcinoma of the larynx. Hayes Martin[1] of the Memorial Hospital, New York City, has given a classical summary of present day opinion on this subject.

> During the past fifteen years, there has been a great deal of partisan, and often prejudiced, discussion as regards the most effective method of treatment of cancer of the larynx. . . .
>
> Fractionated radiation therapy for cancer of the larynx brought about some promising initial results and formerly it was hoped and firmly believed by many that, with further experience and refinements in technique, the method would completely supplant surgery in the treatment of this disease. Such early hopes have not been sustained by the experience of the past twenty years. Radiation therapy will cure a small percentage of cases of laryngeal cancer, both extrinsic and intrinsic. This method of treatment, however, is uncertain and fraught with serious complications that may arise at any time, even years following completion of therapy. . . .
>
> At the present time, it can be stated without question that surgical treatment (partial or total laryngectomy) will cure a higher percentage of cases of both extrinsic and intrinsic laryngeal cancer than will radiation therapy, provided the growth is in an operable stage. . . .

Indications

The indications for laryngeal surgery in intrinsic carcinoma of the larynx are dependent upon the type and extent of the carcinoma:

1. Laryngofissure is indicated when the carcinoma is limited to a single vocal cord without fixation of that cord. Clerf, Putney and O'Keefe[2] stated that in early carcinoma of the larynx (fig. 1A), when the carcinoma is limited to the midsegment of the vocal cord, laryngofissure should result in better than 95 per cent five year cures.

2. Laryngofissure is still indicated when the lesion involves the anterior end of the vocal cord (fig. 1B) or even extends to the anterior end of the opposite cord, utilizing either the "anterior commissure" technic advocated by Jackson or the "window" technic advocated by Kemler.[3] Jackson[1] reported 80 per cent five year cures in

From the Tumor Clinic, Tampa Municipal Hospital, Tampa, Fla.
Read before the Southeastern Medical District Meeting, West Palm Beach, Oct. 22, 1948.

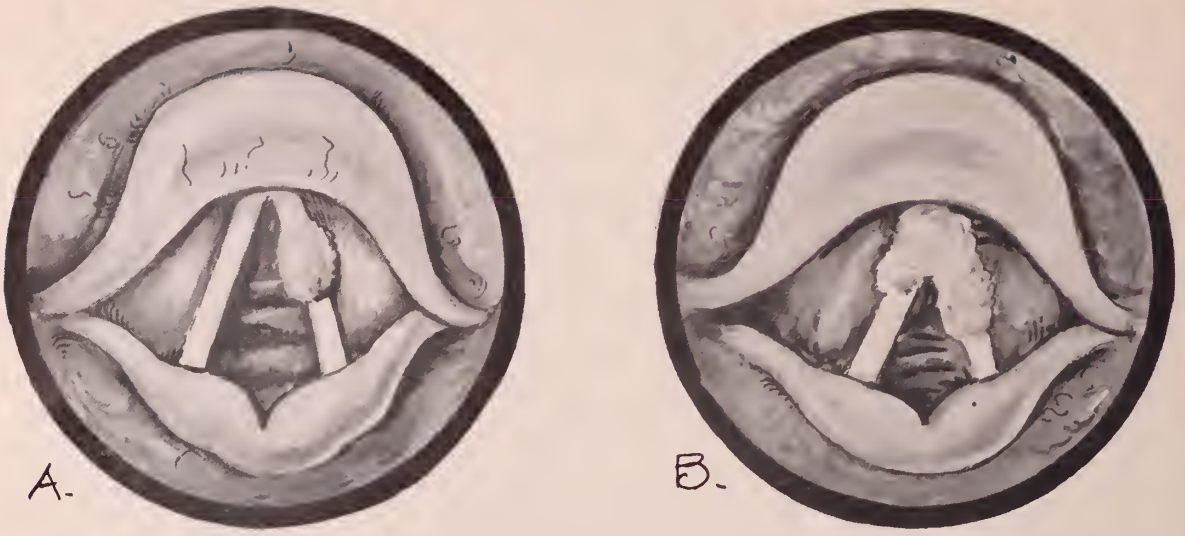


Fig. 1.—A. Laryngofissure should give better than 95 per cent five year cures in lesions of carcinoma of the larynx similar to the lesion shown here.

B.—Laryngofissure will result in about 80 per cent five year cures when the lesion involves the anterior commissure.

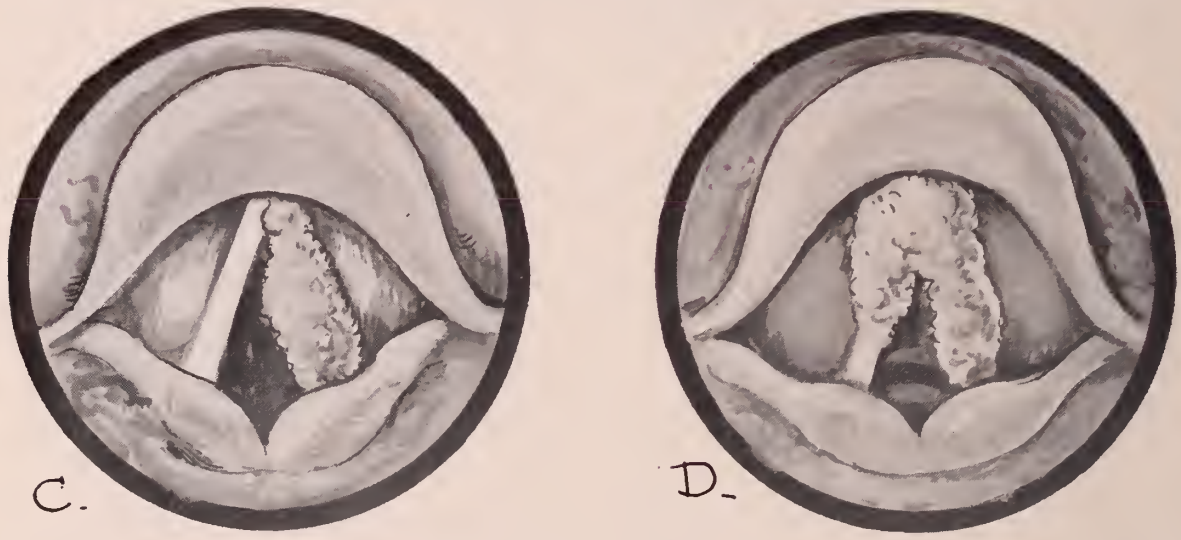


Fig 2.—These photographs illustrate ideal cases for total laryngectomy. In all operable cases, laryngectomy should give 60 to 70 per cent five year cures.

a series of 59 cases of laryngofissure.

3. Total laryngectomy is indicated when the lesion extends posteriorly to result in fixation of the arytenoid (fig. 2C). Total laryngectomy is also indicated when it involves both vocal cords extensively or extends into the subglottic region (fig. 2D). Jackson reported 69 per cent five year cures in a series of 42 cases of laryngectomy.

Surgical Technic

In Tampa, fortunately, there is an excellent medical photographer. His kodachrome slides of recent surgical cases illustrate the technic of laryngofissure and total laryngectomy.

Laryngofissure

In a laryngofissure, the larynx is exposed through a vertical midline incision. After cocainization of the larynx through the cricothyroid membrane, the thyroid cartilage is cut in the midline, or slightly to the side of the unaffected vocal cord. The larynx is then opened with cartilage hooks, exposing the interior of the larynx. The entire affected side of the larynx is then

dissected subperichondrially from the inner surface of the thyroid cartilage to the most posterior extent of the cartilage. The dissection is carried superiorly and inferiorly to obtain a wide margin of healthy tissue surrounding the carcinoma. The mass of free tissue is then clamped at its upper and lower extent and cut free from the adjacent tissue. Then, with curved scissors, the cord is severed posteriorly from the arytenoid cartilage. Hemostasis is secured by ties and electrocoagulation, in order to avoid any postoperative intrinsic bleeding. When adequate hemostasis is secured, the larynx is closed, utilizing interrupted sutures in the external perichondrial tissue. The skin is closed in a vertical midline incision without the use of a tracheotomy tube. If hemostasis has been adequate, the postoperative course is usually uneventful.

In its effect upon the patient for the operative and immediately postoperative period, laryngofissure may be compared to a tonsillectomy for which a local anesthetic is used. The operation itself is performed under local anesthesia, with minor discomforts comparable to those of the tonsillectomy so performed. In the immediate postoperative period, there is some difficulty in swallowing and some pain, but the postoperative pain and discomfort are not nearly as severe as in the tonsillectomy. In the first postoperative months, the patient talks with a forced whisper, which is adequate for communication. Later in the postoperative period, there develops a cicatricial band, which simulates the true vocal cord, and the patient eventually has a fairly adequate voice. In summary, the laryngofissure is usually an uneventful surgical procedure, which offers an excellent opportunity of permanent cure of an otherwise fatal disease.

Total Laryngectomy

With the patient under intratracheal anesthesia, the larynx is exposed through a vertical midline incision, extending from well above the hyoid bone down to the substernal notch. The sternohyoid muscles are retracted, exposing the lateral surfaces of the larynx. The thyrohyoid muscles are removed, skeletonizing the external surface of the larynx. The superior laryngeal artery is ligated. The thyroid gland is cut at midline and sutured for hemostasis. The trachea is then dissected free and cut between the cricoid cartilage and the first tracheal ring. Posteriorly, the mucous membrane covering the lower half of the cricoid cartilage is saved to facilitate closing. At this point, a new intratracheal tube is inserted into the tracheal stump and brought out under the surgical drapes.

The larynx is then reflected first to one side and then the other, and the attachments of the inferior constrictor of the pharynx are severed. The larynx is dissected upward, with dissection of the mucous membrane off the posterior surface of the larynx up to the arytenoid cartilages. The larynx is then replaced in its bed and cut free from the hyoid bone, and the thyrohyoid membrane is cut superiorly. The larynx is again elevated and cut free from the mucous membrane of the hypopharynx. The superior cornua of the thyroid cartilages are cut and left in position. The larynx and epiglottis are removed simultaneously. The middle section of the hyoid bone is removed to permit a better closure of the hypopharynx and soft tissues. With the hypopharynx open, a nasal feeding tube is inserted into the esophagus. The hypopharynx is closed in T shape with a double layer of intestinal sutures. At this point, the wound is thoroughly irrigated in an effort to remove all possible contamination which may have been introduced into the wound from the hypopharynx. The tracheal stump is then sutured to the surrounding skin. The soft tissues are closed, layer by layer, and the skin closed with a small split drain, extending into the angles of the wound. The tracheotomy tube is left in position for the immediate postoperative period. A sea sponge is placed over the incision and adjacent soft tissues, and a pressure bandage is applied to facilitate obliteration of any dead spaces and to insure healing by primary intention.

In the immediate postoperative period, the patient is placed in Sims' position to facilitate drainage from the trachea. Periodic suction is used as needed. He is kept on a full course of penicillin and sulfadiazine therapy. For the first three or four days postoperatively, he is fed through the nasal feeding tube. Thereafter, the feeding tube is removed, and he is able to swallow food through normal channels. Where, formerly, postoperative pulmonary complications and fistula were relatively frequent, these have been practically eliminated by adequate obliteration of dead space and penicillin and sulfadiazine therapy. Operative mortality is minimal.

Rehabilitation

The electrolarynx has greatly facilitated the

rapid rehabilitation of the laryngectomized patient. He begins its use on the seventh postoperative day and, with the minimal of instruction, finds it a valuable means of communication. In all patients, it is extremely useful in the interval between the time of surgery and the time that the patient can learn eructus speech. Although eructus speech is rude, it is an effective means of communication.

Contrary to the consensus among the laity, and medical personnel as well, laryngectomized patients are usually happy patients and rapidly adjust to the inconveniences of their malady. Having been relieved of the anxiety of impending death from carcinoma and, at times, having been relieved of their air hunger, these patients are more frequently exhilarated than they are depressed. They are always extremely happy for their additional years and will often take pride in showing their new methods of speech and communication.

Summary

It is the responsibility of the practicing physicians to educate their patients to the significance of hoarseness as an early sign of carcinoma of the larynx.

Any patient, regardless of age, with hoarseness persisting for more than two weeks, should have a laryngoscopic examination.

Surgical removal of carcinoma of the larynx is the treatment of choice and offers the highest percentage of permanent cures.

The incidence of 49 reported deaths from cancer of the larynx in Florida in 1947 is indicative of grave shortcomings in clinical cancer service. It is my hope that knowledge of the fact that early intrinsic carcinoma of the larynx is a curable disease will reduce this mortality.

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A Type of Anesthesia in Herniorrhaphy with Reference to the Aged

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We who practice on the West Coast of Florida also practice in the geratic domain of the nation. Many elderly persons have hernias of various types, in addition to their arthritic, arteriosclerotic and cardiac conditions. Any elective surgery in this age group requires careful preoperative preparation. Much too often, however, we are called in to see these unfortunate patients anywhere from twelve to forty-eight hours after a strangulation of the hernia has occurred; and there you have before you a situation in which, if the call had only been put off a little longer, the mortician would have been in order, and you would have been saved much grief and sweat. You are confronted with the problem of how you can handle this very sick patient and whether you will be able to relieve him of his condition successfully. Foremost is the question—what type of anesthetic can be administered with the least deleterious effect?

You gentlemen in the metropolitan areas are fortunate enough to have on your hospital staffs trained anesthetists. Some of them practically breathe for the patient, and you are relieved of a great deal of that burden as you gingerly place the problem in the lap of the anesthetist. We in the smaller communities who have to depend on the good graces of our colleagues, or whomever we can collar to give the anesthetic, are confronted with a grave situation.

Classification of Anesthetic Risks

In reviewing the literature, I found a classification of anesthetic risks which is similar to the scale presented by the American Heart Association in classifying cardiac conditions, namely, grades I, II, III and IV.

Read before the Southwest Medical District Meeting, Bradenton-Sarasota, Oct. 20, 1948.

Grade I. Good risk.

Grade II. Fair risk with one or more adverse factors present but nothing serious.

Grade III. Poor risk. Prepare the patient carefully for operation, choosing the least operative procedure that will give the needed relief. Select the anesthetic drug with special regard to the patient's condition.

Grade IV. Grave risk with the patient so seriously ill that death is likely unless the downward progress is quickly reversed.

In applying this classification all conditions of the patient, medical and surgical, are considered, including the operation to be performed. Thus a patient with a toxic thyroid would be a grade III risk, regardless of whether a thyroidectomy or the reduction of a fractured phalanx is proposed.

Factors to be Evaluated

In classifying the grade of risk, the following factors are evaluated:

1. Age. Any patient over 55 years of age is automatically taken out of grade I.

2. Debility. Physical weakness, moderate to severe, places a patient in grade II or III.

3. Nutrition. Obesity is a handicap to breathing in the spinal and inhalation anesthesia, and also increases the trauma of an abdominal operation.

4. Pathologic loss of weight, causing the depletion of glycogen reserves, increases the hazard.

5. The premonition of death augurs ill and increases the risk greatly.

6. The cardiovascular system. If the patient is able to indulge in moderate activity without symptoms, no concern need be felt about the ability of the heart to withstand the slight extra load of the surgical procedure, provided the anesthetic is properly administered. Otherwise the class II cardiac case corresponds to grade III anesthetic risk. Class III cardiac cases correspond to grade IV anesthetic risks. Uncomplicated hypertension only slightly increases the anesthetic risk. The anesthetic risk in cardiovascular cases has been greatly overemphasized, probably because of cardiovascular signs of death being mistaken for the primary cause of death. Heart failure has been written on many death certificates which might better have read "surgical shock, postoperative obstruction of the bowel, hemorrhage, asphyxia from respiratory obstruction or poisoning from overdose of anesthetic agent."

7. Oxygen metabolism. Hypoxemia is the eternal problem to the anesthetist, because the anesthesia may depend upon interference with the cellular oxidation; and several of the inhalation agents tend to displace oxygen in the respiratory tract. Rectal, spinal and intravenous anesthesia often diminish the tidal respiratory volume to the point of producing varying degrees of hypoxemia. One of the most frequent blocks to the oxygen transportation is the blood itself. The importance of anemia in determining the anesthetic risk cannot be overestimated. Thirty minutes of administering the usual inhalation agents produces a significant reduction of the oxygen-carrying power of the blood.

8. The risk in thyrotoxicosis is evaluated on the age of the patient, duration of the disease, loss of weight and failure to gain weight under treatment.

9. Diabetes under control is a grade II risk.

10. Hepatic insufficiency is important because of the detoxifying abilities of the liver.

11. Renal insufficiency. Any operation increases the load on the kidneys. Renal function tests should be used to determine the grade of risk.

Disadvantages of Anesthetic Agents

In reviewing the available anesthetic agents commonly used today, one finds that each presents certain disadvantages and contraindications.

1. Ether has an irritant effect on the respiratory system, and its use is not advisable in patients having infections of the upper part of the respiratory tract or chronic pulmonary diseases.

2. Chloroform offers a low margin of safety and has a toxic effect on the heart and liver.

3. Cyclopropane has a tendency to depress the pulse, cause cardiac arrhythmia or sudden tachycardia. It is highly explosive and is safe only in the hands of a skilled anesthetist.

4. Nitrous oxide is unsatisfactory, first because of its poor relaxing qualities and secondly because in long periods of anesthesia there is a hypoxemia, which is to be avoided in hypertensive, arteriosclerotic and poor cardiovascular states. When it is used in such cases, a highly skilled anesthetist is greatly desired.

5. Spinal anesthesia first presents the problem of entry into the spinal canal, which is often difficult in an elderly patient, who is apt to have arthritic changes in that area. The sudden drop

in blood pressure following its administration is shocking to hypertensive and hypotensive patients. It is not the method of choice in toxic or moribund patients. The danger of hypostatic pneumonia is increased as the patient must lie flat in bed for many hours postoperatively.

6. Pentothal sodium is a respiratory depressant and is contraindicated in the presence of pulmonary diseases. Also as it is a barbiturate derivative and is detoxified in the liver, it should not to be used when hepatic conditions are present.

After examining these agents, it is obvious that no one of them is suitable in every case of grade III or IV risks.

Method Used

Before discussing local infiltration, I should like to digress somewhat. Back in 1939 I had charge of a fifty bed hospital in the Liberian Hinterland. My staff consisted of native boys whose ability to speak English ranged from zero to pidgin. Only two in the group could even make a pretense at writing, and with each that consisted principally of drawing his name. These boys had been trained in haphazard fashion by my German and British predecessors. Needless to say, at the earliest possible time I disposed of most of this group and proceeded to take on a new group, each of whom I taught to jump through the hoop in my own fashion. I might say that in dealing with primitive people it is a waste of time to attempt to teach them the logic and reasoning behind the methods applied in carrying out any procedure. You get it across just by constant repetition of the act until you wear a groove in their thought pattern; thereby any procedure becomes a series of involuntary reflexes with them. I made up one type of surgical pack and regardless of what I did, I would open up the whole pack even though I would only use one or two forceps out of it.

When I first began to operate, I attempted to use ether anesthesia. It was highly unsatisfactory. The first morning my native anesthetist slumped across the struggling patient half asleep. He had received most of the ether fumes. I can still see the ether can rolling across the floor. He next almost drowned the patient with fluid ether. It was too much of a worry to operate and watch the patient; so I quickly discarded the method. Spinal anesthesia was too expensive, as the operating fee was only 5 shillings and the hospital subsidy was very small. As long as I purchased my medical supplies in England and Germany, I was able to get by comfortably, but the war quickly put an end to that source of supply, and drugs from America bought with shillings were too expensive, even though they were wrapped in pretty cellophane packages.

Local anesthesia with me buying novocain in bulk and making up my own solution was my only way out. My recollection of herniorrhaphy attempted under novocain infiltration, as an intern and resident, were not too pleasant; in fact they were more vocal than local. With the injection of the fluid into the tissue you caused a distortion of the structures and landmarks. Attempting to work with these waterlogged tissues was very difficult; furthermore, you did not get very good relaxation of the patient's abdominal wall and were continually fighting with yards of intestine.

While in London I picked up a volume of the Kirschner Operative Surgery, in which the author gave a method of blocking off the intercostal nerves in the midaxillary line that resulted in a relaxed abdominal wall as well as a dry surgical field in which to work. The procedure is relatively simple. I give the patient as preliminary medication 3 grains of nembutal and H.M.C. no. 1. A series of skin wheals is made with 1 per cent novocain solution, starting in the tenth intercostal space in the midaxillary line and extending down to the crest of the ilium. There are approximately three wheals made below the eleventh intercostal space. Then with a 1½ to 2 inch needle approximately 10 cc. of 1 per cent novocain is injected in a fanlike manner at the site of these wheals down through the tissue into the muscle, blocking off the intercostal nerves which descend around the body in an oblique manner supplying fibers to the muscles and skin of the anterior abdominal wall (fig. 1).

When this procedure is finished, the next step is to block the ilioinguinal and the iliohypogastric nerves. These nerves pass downward and come close together just medially to the anterior superior spine of the ilium. They can be blocked by making a wheal just medial to the anterior superior spine of the ilium and through it making a series of injections into the underlying muscles in a fan-shaped pattern, having its apex at the anterior superior spine and the base in the general direction of the umbilicus. The first injection is passed down deep, adjacent to the iliac spine, the others fanning out in the muscle toward the umbilicus. Some surgeons ad-



Fig. 1.—Blocking the nerves of the anterior abdominal wall.

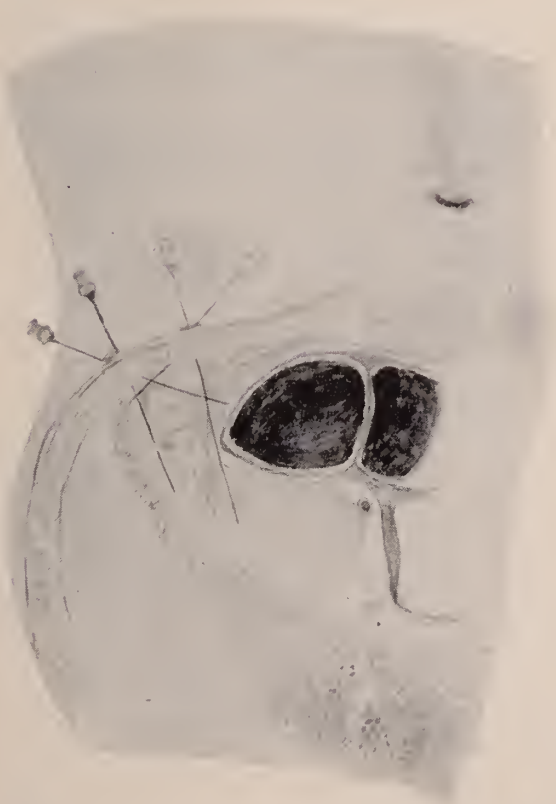


Fig. 2.—Blocking of the iliohypogastric and ilioinguinal nerves.

vise picking up the spermatic cord as it passes over the pubic ramus and injecting it to block off its nerve. I have not found this to be necessary. In repair of bilateral hernias, the injections are done in a like manner on both sides, only carried up to the eighth intercostal space, and I usually repair them by using the Judd incision, which is a transverse low abdominal incision, similar to Pfannenstiel's (fig. 2).

After the injection, I usually wait about five minutes to allow the anesthetic to take effect before operating. I have used this method in over 500 cases, both here and in West Africa, and have had only one failure, this being a novocain reaction. The ages of the patients in this series ranged from a premature infant 6 months old to a blind woman aged 80.

On one occasion I used this type of anesthesia for an exploratory laparotomy with fair success.

Summary

A method of inducing anesthesia by local infiltration of the anesthetic agent is described in which the blocking off of the intercostal nerves in the midaxillary line provides a relaxed abdominal wall and a dry surgical field in which to perform herniorrhaphy.

A series of more than 500 cases is reported in which this method was successfully used, particularly in the aged.

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VOLUME XXXV
NUMBER 10

A Plan of Conservative Management of Antepartum Eclampsia

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Eclampsia, perhaps, offers a challenge as to management which no other obstetric problem presents, for the welfare of the fetus as well as that of the mother must be considered. It is still one of the leading causes of maternal death. Management of antepartum eclampsia is twofold, for that of the pregnant state as distinguished from the eclamptic state is a major problem when labor is not established spontaneously within a short time of control of the convulsions.

Plans for management are somewhat varied, but there is a general trend toward the more conservative approach. It seems that too often there is lacking consistency, because of the varied views presented by authorities in the field of obstetrics. There is no single, well established plan.

The regimen herein outlined is based on the following: (1) conservative management; (2) adapting the various steps in management to the individual patient, with elimination of routine orders; and (3) close personal supervision.

Previously presented were 151 consecutive cases of eclampsia, in which series there were no deaths.[1] To these have been added 6 cases seen in consultation and 3 handled personally, making a total of 160 cases. In this enlarged series, there was 1 death, occurring in a case of intrapartum eclampsia in which the patient was referred to my service in the immediate postpartum state, in coma and moribund. The maternal mortality rate is, therefore, .62 per cent. Of the 160 cases, 86, or 57.7 per cent, are classed as antepartum eclampsia as distinguished from intrapartum and postpartum eclampsia. There were no maternal deaths in the 86 cases of antepartum eclampsia handled by the conservative plan of treatment employed in these cases.

My associates and I recognize five stages of management of antepartum eclampsia: (1) the convulsive stage, (2) the postconvulsive stage, (3) the controlled eclamptic stage, (4) the intrapartum stage, and (5) the postpartum stage.

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Read before the Northwest Medical District Meeting, Live Oak, Oct. 18, 1948.

Management of the Convulsive Stage

When a case presents itself on our service in which there is a history of convulsive seizures, our first concern is the control of these convulsive attacks, this being done even before the diagnosis is established, for regardless of their etiology, we believe that seizures should be controlled. Sedation should be carried to the point of controlling seizures but not deep enough so that the patient cannot be aroused. The patient is given ¼ grain of morphine and 5 grains of luminal sodium hypodermically on admission. It may be stated here that we object to the use of heavy or intravenous sedation. The sedative effect of sodium amytal, for example, is rapidly depressing and predisposes the patient to pulmonary edema and sudden drop in blood pressure which tends to decrease the urinary output. Furthermore, the effect of heavy sedation on the fetus must be considered. The purpose of sedation should be the control of subsequent convulsions and not the control of a seizure in progress for these seizures are of such duration that by the time sedation is prepared, the convulsion is usually over.

If within fifteen minutes the patient seems to be irritable or a convulsion recurs, ⅛ to ¼ grain of morphine may be given hypodermically. If at the end of another half hour, hyperirritability is still present, we use 20 cc. of 10 per cent magnesium sulfate solution injected slowly into a vein. For prolonged sedative effect, luminal sodium is repeated in doses of 2 to 5 grains in order to control restlessness, this being given hypodermically.

A patient should not be disturbed for the purpose of physical examination for a period of approximately an hour after therapy has been instituted, since even minor disturbances may be enough to cause increased irritability. During this period, the patient is placed in a quiet, darkened room and side boards are attached to the bed, but no forcible restraint should be used. Mouth gags are available in order to prevent damage to the tongue and buccal mucosa should a convulsion recur. Oxygen may be easily administered by

nasal catheter, and it is wise to have available a suction machine in order to aspirate mucus from the nasopharynx.

A blood pressure cuff is placed about the arm on admission in order that the patient will not be disturbed as the blood pressure is checked every fifteen minutes for the first hour, and thereafter, every half hour until convulsions are completely controlled.

Establishment of a diagnosis is accomplished by a careful history to rule out previous seizures, with recent complaints elicited from a responsible person. A physical examination should be made with special attention to blood pressure, eyegrounds, evidence of pulmonary edema, cardiac status, reflexes, extent of peripheral edema, condition of the uterus (whether irritable or not), position of the fetus, fetal heart tones, condition of the cervix (whether ripe or unripe), and the bony capacity of the pelvis. Laboratory studies should include a catheterized specimen of urine with examinations for albumin, sugar and acetone as well as microscopic study. The catheter is anchored and drained thereafter at intervals of two hours for the next twenty-four hours in order to check urinary output. In addition, routine blood count and hematocrit determination should be made, the later to evaluate the extent of hemoconcentration, which is usually present in spite of the extensive edema. Blood chemistry determination should include CO_2 combining power, blood sugar, urea nitrogen, and/or nonprotein nitrogen. We do not think that there is any truly typical blood chemistry finding in eclampsia for it is our belief that the readings of uric acid, for instance, vary considerably from case to case. These studies are done primarily to rule out other conditions.

It has been found that should the schedule of sedation mentioned not control the hyperirritability, spinal puncture may be done. This is often of considerable value both from the therapeutic and diagnostic standpoint.

Before initiating actual therapy, the diagnosis of eclampsia must be confirmed. Intravenous fluids are limited to the smallest amounts necessary to establish a satisfactory urinary output. There is considerable danger in the use of large quantities of fluid by vein for this may result in an acute pulmonary edema with cardiac embarrassment. Intravenous medication is continued only so long as the patient is unable to take sufficient fluids by mouth. When pulmonary edema is present, 50 cc. of 50 per cent dextrose in distilled water is given intravenously. In cases in which by hematocrit reading it is found that there is a hemoconcentration in spite of the peripheral edema, 100 cc. of 5 or 10 per cent dextrose in distilled water is given by slow drip. The average patient, however, receives 500 cc. of 20 per cent dextrose solution in distilled water given intravenously by drip so as to cover a period of forty-five to fifty minutes for its administration. For the next four hours, we consider 20 to 30 cc. of urine per hour as adequate output, and should the output be less than this amount, 300 cc. of 30 per cent dextrose is administered, or 50 cc. of 50 per cent dextrose is given intravenouly. Since in most of these cases there is a low serum protein, plasma is frequently of value in overcoming oliguria.[2]

Management of the Postconvulsive Stage

The postconvulsive stage is that period which follows the final convulsion and precedes the return of full consciousness. It is a period of gradual improvement with episodes of hyperirritability and one during which treatment must be highly individualized, depending on the response of the patient to therapy. It must be remembered that though convulsions are under control, by no means is there assurance that they will not recur. We think that attempts to terminate labor at this period are contraindicated.

Sedation is again limited to an amount necessary to control any evidence of hyperirritability. The doses required are usually less than those used in the convulsive stage, and 1½ to 3 grains of luminal sodium at intervals of three to six hours is usually sufficient.

The use of intravenous fluids in this stage of management is limited, and as soon as the patient is able to take fluids by mouth, she is given 200 cc. an hour. This includes highly sweetened fruit juices, water, Coca-Cola and milk. Certainly, there is no danger of overloading a patient with fluid when it is taken by mouth. The urinary output is usually markedly improved in this period following the oral administration of liquids.

Further, under management at this stage, it is suggested that oxygen therapy be continued, blood pressure determination be made every hour, and urinary output be carefully checked at two hour intervals. As soon as the patient is able to take liquids by mouth, a large dose of magnesium sulfate is given (1½ ounces of a saturated solution of magnesium sulfate.)

Management of the Controlled Eclamptic Stage

The controlled eclamptic stage embraces the period between the control of the convulsion and the onset of labor. There is usually definite improvement, and complete disappearance of acute toxic manifestations is not unusual. There may be recurrences of hyperirritability, but generally it is a stage of improvement. Little sedation is required, and fluids are forced orally. The urinary output improves, and there is a gradual decrease in albuminuria which is at first slow but rapidly improves. The peripheral edema gradually disappears. The blood pressure is found to be stabilized, and the patient seems gradually more oriented.

The extent of improvement varies considerably, but there is a decided change from day to day. Frequently, we have stated when seeing patients in this stage that the appearance is that of a very mild pre-eclampsia.

Of the 86 cases of antepartum eclampsia, 54, or 62.7 per cent, were classified as intercurrent eclampsia. This term was used to designate those cases in which the interval between the final convulsion and delivery was more than seventy-two hours.[1]

Careful observation during this period is imperative, and no matter how great the improvement, the patient should be hospitalized through the postpartum period. No longer is an indwelling catheter necessary, but accurate outputs are charted every eight hours. Careful tabulation of intake is also kept over eight hour periods. Daily urinalyses, with special reference to albuminuria, are ordered. The patient is given a low salt, high protein, low fat diet. Fluids are forced orally with 4,000 cc. for a twenty-four hour interval being the goal. As sedation, phenobarbital, grains 1½, is given every night at bedtime and withheld during the day unless there is evidence of irritability. Oversedation is again avoided.

The termination of pregnancy is an essential feature of the plan in management. We believe that as long as there is clinical improvement daily, there is no indication for termination of the pregnancy, and induction of labor or operative delivery should be postponed until the patient is in optimum condition or at least until the blood pressure is well stabilized and albuminuria has decreased. We condemn induction of labor during or immediately after the convulsive stage when this is done with the purpose of stopping the convulsion. In our opinion this definitely increases both the maternal and the fetal mortality rate, for both patient and fetus are in the poorest physical condition to tolerate the process of delivery. We do not mean to insinuate that any measure is taken to halt labor should it be initiated spontaneously regardless of the stage of eclampsia in which it ensues.

Delay of termination of pregnancy until definite improvement takes place is advantageous from the standpoint of the mother because it affords her an opportunity to recover from the strain which is incident to eclampsia itself. From the standpoint of the fetus, delay is also advisable because chance for recovery from the toxic maternal state is permitted, as well as recovery from heavy sedation necessary to control the eclamptic state. It must be remembered that traumatic procedures to induce labor or hasten delivery affect the fetus adversely.

Pregnancy should, however, be terminated without delay when response to therapy is unsatisfactory or when a relapse occurs. We prefer induction of labor with vaginal delivery as a rule, unless obstetric indication for cesarean section is present.

Hurried attempts to empty the uterus are undesirable. We prefer a medical induction even though it is a slow process and may be repeated several times before it is successful. Our usual routine consists of the following: At 6 a.m., the patient is given 1½ ounces of a saturated solution of magnesium sulfate by mouth. Four hours later, she is given a high, hot enema which is to be retained for a few minutes. At 2 p.m., if no contractions have ensued, ½ minim of pitocin is given subcutaneously and is repeated every twenty minutes on an average; each time the amount injected is increased by ½ minim until rhythmic contractions ensue or until the maximum dosage of 3 minims has been reached. Several attempts may be made to initiate labor before success is attained. Each attempt, however, softens and shortens the cervix and increases uterine irritability until labor finally sets in. If it seems imperative that labor be established and if this routine has failed to produce labor, a sterile vaginal examination is done. The vagina is irrigated thoroughly with zephiran chloride (1:1,000 solution) after the usual preparation has been carried out as far as the external genitalia are concerned. An examining finger is gently introduced through the cervical canal, and the cervix is stretched gently so as to admit

an additional finger. The stretching is carried out slowly so as to consume about fifteen minutes. The membranes are then stripped from the lower uterine segment. Following this procedure, there is a period of two hours allowed in which the patient is observed, and if contractions are not established at the end of this time, pitocin induction is repeated. We seldom resort to rupture of the membranes to induce labor.

Management of the Intrapartum Stage

The intrapartum stage of management includes the period of active labor and delivery. When improvement has been remarkable and there is little residual of the eclamptic state, management during this stage differs little from that of the average patient in labor. On the other hand, if labor ensues or is induced for reasons of having failed to respond to therapy and consequently is superimposed on the patient who is not in optimum condition, this stage requires close observation and extreme caution. If the patient has not reached optimum condition for labor and delivery, sedation should be such as to prevent increased irritability, and yet care must be exercised so that the patient is not overly sedated, again predisposing her to anoxia, cardiac embarrassment and pulmonary edema. The blood pressure is checked at frequent intervals. The fluid intake must be maintained, preferably by intravenous route, with the use of dextrose (usually 10 per cent dextrose in distilled water).

These patients tolerate poorly traumatic procedures, loss of blood and prolonged inhalation anesthesia. Bearing this fact in mind, delivery must be planned to reduce trauma to a minimum and this should be, if possible, effected under local anesthesia, in combination with the sedation used throughout labor, rather than to rely on inhalation anesthetics for delivery. Blood should be held available in the delivery room at the time of delivery, for, as stated, loss of blood is tolerated poorly, and furthermore, there is the tendency in this type of case to vascular collapse following delivery. This condition is best combated by immediate use of blood.

Management of the Postpartum Stage

There is, too often, the feeling that once an eclamptic patient is delivered, nothing can go wrong. Close observation in the immediate postpartum period is imperative. Convulsions may recur if the patient becomes hyperirritable, and in the event that they should recur, a 1/6 grain of morphine and 3 grains of luminal are ordered given hypodermically. As mentioned previously, peripheral vascular collapse is a common complication following delivery, and the patient should be watched with this in mind for at least an hour afterward. As a precaution, an infusion of 500 cc. of 20 per cent dextrose is started at the time of delivery, and the rate of administration should be such that the entire amount is administered over a period of forty-five to fifty minutes. Blood pressure should be checked at fifteen minute intervals for the next twenty-four hours. After this time, the blood pressure is taken twice daily for the remainder of the stay in the hospital. Urinary output is carefully charted at eight hour intervals for the first twenty-four hours and thereafter on a twenty-four hour basis. Urinalysis is ordered daily. The period of hospitalization following delivery should be ten days.

It should be stressed in talking to the patient on the date of discharge that she be followed at regular intervals for the remainder of her childbearing period.

Discussion

We believe that the figures submitted here are evidence that maternal results are better when close observation and a conservative and highly individualized routine are followed. Our plan of management is certainly diametrically opposed to that of the proponents of immediate emptying of the uterus once the diagnosis of eclampsia is established. We believe, however, that our point of view is justified when we consider the excellent maternal results.

Regarding fetal results, it may be stated that the longer the interval between convulsions and delivery the higher the rate of survival. Ninety babies were born to 86 mothers. Of these, there was a gross fatality rate of 28 fetal deaths, or 31 per cent. The fatality rate of 13 of 57 babies delivered to the 54 mothers in the group of intercurrent eclampsia was 22.9 per cent; this is certainly lower than the fatality rate for 15 deaths among 33 babies born to 32 mothers in the group delivered within three days of the convulsions, which was 45.4 per cent. These figures would lead one to believe that the conservative management enhances the chances of survival of the fetus. We consider this an additional argument in favor of the conservative treatment.

Summary

We have presented a plan for the management of eclampsia which is based on three points: (1) conservative management, (2) adapting the various steps in management to the individual patient with elimination of routine orders, and (3) close personal supervision.

One hundred and sixty cases of eclampsia are reviewed, in which there were 86 cases of antepartum eclampsia. In this group, there were no maternal deaths.

To summarize, we conclude that the maternal mortality is lower and the fetal salvage greater when a closely supervised conservative regimen is followed.

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General Principles in the Treatment of Tuberculosis

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This subject "General Principles in the Treatment of Tuberculosis" is indeed a broad one. To restrict somewhat all that it might imply, will you please go along with me as we take the patient at the time the diagnosis of tuberculosis is made and follow him through the months or years he is under medical surveillance? In my mind there are three definite periods in each patient's episode with tuberculosis, not the least important of which is the interval between diagnosis and treatment.

First Period

The period when the patient receives his diagnosis and prepares for hospitalization calls for clear thinking, careful explanation and truthful answers. We are dealing with and planning for the next year or two of that patient's life, outlining, if you will, a comprehensive plan that will lead to his ultimate recovery. This is to include his preparation for admission to the sanatorium, the period in the sanatorium, and last, but certainly not least, his postsanatorium life, that period during which we must help him guard against any reactivation of his disease.

When a person is told that he has tuberculosis, the diagnosis is usually met with great emotional shock and frustration. No patient actually receives the diagnosis without some manifestation of doubt, discouragement, despair, or mental anguish. In the majority of cases the realization comes with a profound violence. His having tuberculosis is something incredible; it has never once entered his mind. Certainly he has heard of tuberculosis, and he may even have observed it in some friend or member of his family, but it has never before touched him personally. Now, the diagnosis of tuberculosis is made in his case, and invariably his first reaction is one of rebellion or abject depression.

The knowledge that the average patient has of tuberculosis is extremely limited. He believes only that here is a disease that has always had a high mortality rate, a wasting, chronic, incurable disease, the victim of which is generally feared, ostracized and shunned. The reason for this belief is that too many people have paid little or no attention to the constant and thorough health education that has been going on for years through the national and local Tuberculosis and Health Associations.

The doctor's initial approach can hopelessly terrify or confuse the patient, or, if administered with tact and understanding, can convince him that here is great hope, that life may still be full and rich. He must be cautiously led through this period which usually carries with it a large measure of despair. He must not be allowed to go off on some tangent and seek a quick cure, of which there is none; neither must he be allowed to assume an attitude of indifference, nor sink into one of despondence. Now, more than at any other time, he needs counsel, whether it be from his doctor or a member of some welfare agency.

Many persons do not know that the city, county or state in which they reside provides a special hospital for cases such as theirs. They never have had occasion, nor necessity, for occupancy in such an institution. Fewer than you would suppose know that public taxation provides for such care. Tuberculosis demands extensive and

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prolonged treatment, the expense of which is prohibitive to the average family, without some assistance.

Naturally the patient has the solicitude of his family at heart, and he cannot relinquish anxiety or make any progress as long as he is harassed with concern over their finances. Here we must consult with welfare agencies and relief organizations, for they are the ones to assist in matters financial, to make provision for the care of small children and in every way try to maintain the family unit while the patient is absent from the home.

Since the old idea of stigma still persists, many a patient bitterly resents his diagnosis on that score. He begins his cure with a feeling of great personal persecution. While every effort should be made to assure him that tuberculosis is no respecter of persons or classes, I find that the sanatorium will usually dispel such bitter feelings. Therein lies the great psychologic benefit of going to a sanatorium. The association of other fine people who are likewise burdened is the inspiration he needs. No one who has taken the cure but remembers those first grievous days in the sanatorium, nor the triumph that comes later with the arrest of his disease.

The patient practically always asks "How long will I have to be there?" This query can be answered best, I think, by stating that the sanatorium doctor can determine the length of time after a thorough physical examination and the customary roentgen and laboratory studies have been completed. At this point he should be informed as to what sanatorium life is, what he may expect, and what he must do to gain a recovery. He, too, must accept some of the responsibilities of his case. Nor must his family be ignored. If families could only be made to understand how important it is to maintain a calm and cheerful attitude, they could be a tower of strength to the patient.

Every assistance should be given him in filing his application through the proper agencies, beginning with the forwarding of the roentgenogram of his chest to the sanatorium with the application.

This first period may not seem too significant in the "General Principles in the Treatment of Tuberculosis," but it is the initial step, and as such is an important phase on which much depends.

Second Period

Now comes the period—"The Patient in the Sanatorium"—a new type of living for each patient. His powers of adjustment to his new environment, to the acceptance and toleration of his tuberculosis are indeed taxed. The staff and all others at the sanatorium are strangers to him, and he undoubtedly feels very much alone and discouraged.

His doctor and his nurse now come into his life, and their approach and their first words can be of immeasurable comfort. The doctor to whose floor or service the patient is admitted should make it a point to see that patient as soon as possible, to impart a word of welcome and to outline a brief sketch of what the next few days may contain, namely, the routine of careful physical examination, another roentgenogram of the chest and blood, urine and sputum studies. A great many of these people have never been in a hospital before, know nothing of hospital procedure. During this visit the doctor observes the patient as he really is on admission and can determine to some degree his psychologic approach. This initial interview can, therefore, do much for both the patient and the doctor.

We all know that rest is certainly the most important prescription—general rest—the entire body is "at ease." Here the patient first begins to learn what the word "rest" actually means. Few patients have really been at rest while at home awaiting admission. The lungs are vital organs, and in order to bring about pulmonary rest, the entire body must join in to help the affected lung recover. Any thing that we can do to lessen respiratory effort and frequency must be used. If one can reduce the number of respirations by only 4 a minute, that means 240 in every hour and 5,760 each twenty-four hours. That is our first objective. Next, by bed rest we can reduce the heart rate. If the heart can be made to reduce its pulsations by only 8 a minute, we have 480 per hour and 11,520 per twenty-four hours.

Now, let us consider the body temperature, which is easily raised by tuberculosis. There is nothing like bed rest to bring about a normal body temperature. Actual rest does reduce the toxicity of the patient's disease. It lessens absorption of toxins, it permits absorption of recent spreads and infiltrations, and it permits the more rapid formation of healing tissue, fibrosis or scar tissue.

So many patients complain of indigestion, gas and allied stomach symptoms. They at home have been forcing foods, especially rich foods, such as raw eggs, malted milk and eggnog.

A patient should be put on three full meals a day. Bed rest and proper timing of meals will

cure more dyspepsia, gas and like symptoms than the majority of dyspepsia pills and powders. We must remember that if a tuberculous patient abuses his stomach, he invites indigestion. His stomach cannot stand the insult of highly concentrated foods every two hours without becoming embarrassed. Patients will do better on three good meals a day, will gain more weight and have fewer gastric symptoms.

Mealtime in a sanatorium occupies three particularly important periods in each day of a patient's life. He should endeavor to eat slowly and properly masticate his food. Each mealtime should be a period of relaxation to satisfy a stomach which is ready and willing to receive a good meal. The daily diet should contain a minimum of 3,000 calaries. All dairy products should occupy a prominent part in the patient's intake inasmuch as these products are rich in vitamins A and D and no tuberculous patient ever recovered without an ample supply.

Eating between meals destroys the appetite for a good, full meal and should be discouraged. If brought-in foods are allowed, they should be eaten at mealtime only. I am a nonbeliever in foods being brought in, with the exception of fruits and salted nuts; the latter contain vitamins and fats. I do not subscribe to candy as it is usually eaten between meals, but in place of candy I permit chewing gum. I believe that it does at times help to reduce the dryness of the throat; therefore, it may reduce the cough reflex, and, too, the patient is getting some form of a confection.

Certain patients may have to be fed oftener than just three times a day. I refer to the patients receiving pneumoperitoneum. Pneumoperitoneum seems to reduce the capacity of the stomach, and a full, large meal will not be tolerated. Also, postoperatively, patients must receive particular attention.

The diabetic patient is always a great concern. On admission this patient must receive a thorough study as to his carbohydrate tolerance, his blood sugar and his insulin dosage, if that is required.

Patients who show on physical examination an avitaminosis should receive increased doses of vitamins besides the three meals a day.

All patients must be made to realize that fancy foods, confections and barbecued sandwiches lend little to their nutrition. The patient must make many sacrifices as the road to health is not easy; indeed, it requires a great deal of self discipline to maintain a pattern of life so that the disease remains under control.

Today, in addition to the application of general body rest, we possess many useful and successful methods of applying localized rest to the sick and diseased lung. In addition to local rest, we must use bed rest as well, in order to get the most from sanatorium care.

I shall not go into the indications for, nor the technics of, the different forms of collapse therapy.

When the patient's case, with all available data, is brought to the staff meeting, the decision as to what type of compression therapy shall or shall not be used is made. Rarely do we find two cases alike. I like the counsel of more than one doctor who knows the indications and has observed the results of the various methods of this type of treatment.

I believe that today almost every sanatorium will record that from 70 per cent to 75 per cent of the patients are receiving some form of collapse therapy. Phrenic nerve block is perhaps the simplest form of surgical rest for the lung. This is a temporary paralysis of the nerve; rarely is a permanent paralysis indicated.

Artificial pneumothorax properly used with intelligence and technical skill is well tolerated and can be very successful. The duration of this procedure over many years is, however, to be condemned. We are seeing too many patients today who have had years of repeated pneumothorax refills, only to have this therapy terminate with an unexpanded and atelectatic lung, and too frequently, a complicating tuberculous empyema. When to stop refills is most important and many time not easy to determine. Too many patients are told that "all you have to do is to take pneumothorax." They forget about other necessary and obligatory habits which they must form so that their disease will remain controlled.

I do not believe that a pneumothorax should be carried over twenty-four to thirty-six months at the most. If adhesions are present, the patient deserves an exploratory thoracoscopic examination. If feasible, the adhesions should be severed. If the surgeon believes a lysis is not justified, the pneumothorax should be abandoned and another form of collapse therapy considered because the indications for collapse still pertain.

Pneumoperitoneum occupies a well deserved place in our armamentarium. It is well tolerated; there are fewer complications than with pneumothorax, and it may well be used in combination with a phrenic nerve block. In many cases it can be used as a steppingstone to major surgery. I have seen in many cases so much improvement

that the disease becomes arrested, and major surgery, which was included in the original program for the patient, was not necessary.

Our major surgery includes: extrapleural pneumothorax or oleothorax, thoracoplasty, and section, which is the removal of a lobe or entire lung.

No surgical program should be attempted without a trained and competent thoracic surgeon. The preoperative treatment cannot be passed over lightly. The surgical theater should be well supplied with proper personnel, experienced in this highly technical work. We must remember that thoracic surgeons and their assistants cannot be trained in a short time.

Too much stress cannot be placed on postoperative care. After all the work on the patient before the operation, followed by the skill and the technics of competent and trained surgeons, we cannot afford to lessen or decrease our efforts at this stage. With transfusions, oxygen, intravenous medication and fluids, and constant watch over the blood pressure during the days and nights that follow major surgery, our hands are full of watchful expectancy. Only the trained personnel, our surgeons and our nurses, are capable of assisting the patient with major surgery. They must be ready to anticipate and meet any emergency. We must remember that in all cases of collapse treatment there is just as much tuberculosis present in the lung the day following surgery as before. Major collapse merely places the diseased lung at practically complete and permanent rest.

Now begins the long period of bed rest to permit adequate fibrosis and healing. Symptoms, including expectoration, pain, cough and distress, must be met with and properly interpreted and treated.

In some cases there may be proper indications for the complete removal of one lobe of a lung, or even the entire lung itself. This, indeed, requires skill of the highest order and the postoperative care requires constant, selected attention for many days.

The question of chemotherapy and antibiotic therapy must be answered. The administration of streptomycin must be considered but only in those cases in which research and experience have shown it to be really efficacious. Its widespread use is to be condemned. Streptomycin has its place in acute types of tuberculosis, in endobronchial, laryngeal, preoperative and postoperative cases, in extrapulmonary disease and in draining sinuses. This antibiotic should be given ½ to 1 Gm. in divided daily doses over a period of about forty-two days, and in some cases even smaller doses are advised. Toxic symptoms, such as vertigo, loss of hearing, renal damage and dermal changes, may occur. Despite the wide publicity it has received, streptomycin is not a cure-all; it is only an adjunct, a booster, if you will, in selected cases. Streptomycin has its place and should be kept there. Experience and great caution must be used in administering this drug.

The far advanced, terminal and maximum benefit cases should be hospitalized, as far as possible, in single rooms. They require more nursing care and attention, they usually have more visitors, and this separation bids well for the patients whose condition shows improvement.

I am definitely opposed to smoking or other uses of tobacco. Smoking tends to retard digestion and increases bronchial irritation. We see more tuberculosis of the larynx in smokers than in nonsmokers. It is indeed just another habit that a patient must give up while under treatment.

As the condition of patients improves and increased physical activity can be considered, a real plan of graduated exercise now comes into the picture. The doctor on the service and the combined staff must be the judges and directors, while the nurses must understand and supervise this period of slowly increasing activity. The doctor's good judgment is gained only by experience, and the patient must necessarily heed his orders and prescription for exercise.

During the period of getting the patient up, let us err on the side of safety rather than proceed too rapidly. Let there be no gambling at this point. If this plan of increased exercise is carefully explained to the patient, his great eagerness to get up will be moderated with common sense and the final success is more assured.

Now is the time for our great and good facility —occupational therapy—to creep into the program. The restless anxiety of many a patient has been eased and sedated by his accomplishing something with his hands. Let it start with bedside direction and supervision according to the doctor's advice. As the exercise of the patient increases from month to month, many can participate in one or more of the following projects in use daily in the Florida sanatoriums:

1. Blood Bank
2. Clothes to and from the cleaners
3. Entertainment Committee

4. The Florisan Club
   (a) Executive Committee
   (b) The Patients' Council
   (c) The Membership Committee (new patients)
   (d) The Patients' Own Store
5. Hairdressing
6. Information Desk
7. Patients' Library
8. Mail Service to Patients (Pick-up, delivery and money orders)
9. Daily Newspaper Delivery
10. Religious Committee
11. The Sanatorium Magazine
12. Occupational Therapy Assistants (Teaching other patients knitting, needle point, leather work, and the like)

At the beginning of the patient's sanatorium life many "don'ts" were injected into his daily routine. Now we are beginning to replace the "don'ts" with "do's." Every increase in exercise must be recognized by the patient and his family as a test for the tolerance to physical activity without producing any symptoms whatsoever. As the patient exhibits his ability to tolerate increased physical activity with his clinical picture showing no evidence of harm, he can, with safety, have gradually longer periods of being out of bed, can assume such duties as are listed in the occupational therapy plan. We must remember that this program occupies many weeks and months. Judgment, planning and the estimate of tolerance to physical activity are carefully weighed.

As soon as the patient reaches the period when he is able to be dressed and is enjoying at least one meal in the main dining room, the rehabilitation counselor must now appear on the scene. The counselor may discuss with the patient the advisability of vocational guidance and training. He should review the case with the medical director or the staff physician, the occupational therapist and the medical social worker so that he may have a comprehensive picture of this patient.

Two to three weeks prior to the time of discharge, it is well to notify the patient's family, the County Health Unit, the local Tuberculosis and Health Association secretary, and any other allied agency, that the patient, whose disease is now apparently arrested, will soon be ready to return home. Thus the agencies then have time to ascertain whether or not the home is ready to receive this patient, and any investigation relative to home conditions can be made. Thus begins the follow-up of this case.

Third Period

Our work does not begin at the door of the sanatorium, nor does it end there. Tuberculosis is prone to relapse, and without guidance, care and follow-up work the patient's disease may again become active. Let us follow the patient after discharge. I advise all rest hours for three months, then the first recheck roentgen study, and if all is well, the morning rest hour may be reduced by fifteen minutes a week. The afternoon rest hour should be continued for months, sometimes years.

The patient, after many months, and even years, in the sanatorium, must learn to live with normal people again. I like to call it "getting housebroke." If the patient has had a permanent collapse, schooling and vocational training at home can well start at the end of the third month, provided the roentgenogram is favorable.

In cases of temporary collapse, such as pneumothorax, I like to allow a six months' period to elapse before attempting any increases in physical activity, to be sure that the pneumothorax has been properly carried out and that the patient is well adjusted.

The first year out, I recommend that the patient have a roentgen examination of the chest every three months, each roentgenogram to be compared with his previous roentgenograms. Every three months his hours of work in his training course, or in his business, may be increased, all of which must be carefully outlined for the patient.

Conclusion

The "General Principles in the Treatment of Tuberculosis" are few; the details are many, and in each case must be individualized. Let us always remember that each case of tuberculosis represents a person. Would that each case could be ideal!

Our work combines a careful diagnosis, judicious guidance, proper and timely treatment, continuous and constant follow-up of cases; and by the consummation of such efforts, we cherish the hope of restored health to each individual patient entrusted to our care.

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Progress in Public Health in Florida

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Largely as a result of recurrent epidemics of yellow fever, the state constitution of 1885 provided that there should be a State Board of Health which would supervise all matters relating to public health in the state of Florida. This step had been urged for many years by the Florida Medical Association and in particular by Dr. Joseph P. Wall of Tampa, a former president of that Association. He is considered by some to be the father of the State Board of Health. The constitution further authorized the establishment of county boards of health, but this step was not mandatory as in the case of the State Board of Health. Nevertheless, county boards of health were established by the legislature before any steps were taken to establish the overall state agency.

Florida suffered a severe epidemic of yellow fever in 1888 centering around Jacksonville, which disrupted the business and economic life of the entire state for many months and cost the state not only a great deal in dollars and cents but also many lives. One of the things that added to the general confusion of the situation was the fact that the county boards of health proceeded individually according to their separate ideas in dealing with the epidemic. Many quarantined their neighbors by force of arms and by other methods so that normal travel in the state was impossible and no one knew at what point he might be stopped. Even articles of commerce and letters were required to be fumigated or their movement altogether prohibited. As a result of the chaos that prevailed at that time the Governor called a special session of the legislature early in 1889, and an act was passed creating the Florida State Board of Health. Dr. Joseph Y. Porter became the first State Health Officer, he having distinguished himself by his work during the epidemic in Jacksonville. He continued in that position and served with the state until 1917. A few years after his appointment, because the county boards of health did not acknowledge the application of the State Board of Health's regulations within their domain and because some confusion thereby continued, the county boards of health were abolished altogether, and county agents of the State Board of Health were appointed for each county.

The early history of the State Board of Health would occupy a large volume in itself, and I have studied the old reports only enough to have a superficial knowledge of events of that time. I could not do better than to summarize the activities of the agency during its first twenty years by quoting from the statement by E. M. Hendry, president of the State Board of Health, to the Governor in transmitting the annual report of 1909 as follows:

> It is not my purpose to more than direct your attention to certain features of this report which to me are particularly interesting from a business man's point of view and which seem to bear especially upon the State-wide influence which the Board has induced during the past twenty years and from which great good has resulted to the people both educationally and practically.
>
> It is a well known fact that prior to the great epidemic of yellow fever in 1888 the increase in the State's population from immigration was almost inappreciable compared with the gain since the period mentioned. It is within the memory of even our younger people that as each summer came there was talk of yellow fever, its probability of occurrence and the point where it would first make its appearance. This periodic agitation of a subject which vitally interested not only the physical life of the citizen, but his business existence as well, brought about conditions which yearly disturbed home comfort and retarded the coming of people into the State, besides restricting investment of capital, so necessary to develop many important industries and avenues of commerce which held out flattering returns. People were scary, and naturally so in placing their money where health conditions were so uncertain and where an epidemic of yellow fever depressed values to a degree that it would take years of exemption to recover from. Then again, the diversity of opinion as to management when disasters of this character did occur and the inconvenience and annoyance to travel and commerce which arose on each county line, demoralized both the citizen and business, so that at almost every path and by-road in the State, the traveller, whether from an infected portion of the State or not, was harassed by guards, who in the majority of instances were ignorant of the essential requirements of their positions, and who rendered really no practical service in restricting the spread of a contagion, but did inflict, by their orders and insistence of them, many indignities on women and children, and in several instances serious impairment to health.

He further pointed out the difference in conditions in the state during the yellow fever epidemic in 1888 and an epidemic which occurred

State Health Officer.

Read before the Florida Health Officers' Society, Third Annual Meeting, St. Augustine, April 11, 1948.

in Pensacola in 1905. He continued: "In 1905—in the latter instance—without a ten-mile area around Pensacola travel within the state was undisturbed. Business followed its usual methods and there was no panic, no excitement no hysteria of even those most sceptical of the ability of the State Board of Health to cope with the situation." He pertinently inquired: "Would people come to the State from the West, Northwest, Northeast, and middle West, buy property, institute new industries, and settle permanently among us, if they did not feel that their lives were being guarded against disease, and their accumulations of property interests were being protected against needless fright and senseless panic?"

It is hard in the year 1948 to realize the uncertainty that prevailed here during these years as to life and health. During most of this period and before it, the term "season" was generally used to refer to the summer months when yellow fever and other diseases prevailed as contrasted with the use of the term at the present time referring to the winter tourist season. The annual meeting of the State Board of Health was fixed by law to take place on the second Tuesday in February so that sanitary rules and regulations could be fixed and the public advised of them well in advance of the fever "season." Unfortunately, we have very few reliable figures on birth rates or general death rates by diseases for the first years of the Board's existence. It would be of great interest to us to be able to compare death rates and the occurrence of various diseases in 1889 and at present. Unfortunately, this is impossible. Dr. Porter recognized this handicap almost at once and vigorously and continuously advocated the establishment of a Bureau of Vital Statistics until this was finally brought about in 1917. We have every reason to believe that progress made prior to that time was remarkable, but we cannot offer too much statistical evidence to show the progress that was made.

We do, however, have good figures since the year 1917, and a little later I shall show you some charts and tables illustrating progress made in public health in the state, of which we can all be proud. I should like to emphasize, however, that it would be presumptious for the State Board of Health to claim credit for all these accomplishments. We share with the private physicians of the state especially the honor of having been workers in this field. We must also remember that a large share of these accomplishments must also be credited to workers other than physicians in the field of public health and out of it. The betterment of economic conditions has certainly contributed immeasurably to the decline in mortality in tuberculosis and for that matter all the other diseases including those of enteric origin. For instance, the plumber has certainly made a definite contribution in the betterment of sanitary facilities which cannot be disputed.

Not the least of the factors that have influenced the health situation in Florida favorably has been the increasing knowledge on the part of the public of health matters and of the steps necessary in order to stay well. I am proud to report that the State Board of Health recognized very early the part that health education plays in a total health program. As early as 1892 the Board began the printing and distribution of the monthly magazine "Health Notes" with the avowed purpose of educating the public rather than restricting such information to physicians and health workers. Except for a few short intermissions this publication has been printed continuously until the present time.

Because the people of the state have apparently thought that a public health program was a worth while investment, the annual state appropriation has increased from a beginning of $50,000 per annum (but only about $25,000 per annum was made available for several years) to $1,500,000 at the present time, this latter figure not including federal and local funds. There is evidence to show that the volume of work done has kept pace with the public demand and with the availability of funds. As an example I may cite the fact that during the ten year period 1906-1915 the Bureau of Laboratories performed 164,837 tests and examinations while during the period 1938-1947 a total of 11,439,161 tests and examinations were performed, a seventyfold increase. I could cite for you many other evidences of performance on the part of the Board and its employees, but the one mentioned is perhaps sufficient.

After the first world war there was a revival of interest in local health departments. A campaign for the establishment of county health departments was, however, nipped in the bud by a reduction in the appropriation for the State Board of Health, and interest did not again become general on this subject until a decade later. One of the milestones in the history of public health in the state that should never be forgotten was the passage of an act in 1931 to authorize the establishment of county health units. This

is one of the finest and soundest enabling acts that I have encountered in the country and has stood the test of time without amendment up to the present. The act not only avoids the confusion of providing for entirely independent local health departments, which would result in the same confusion and lack of coordination as existed in earlier years, but also provides for a decentralization of administration and responsibility to local officials. You all know what progress we have made in the establishment of county health units since that time. All but five small counties now have full time health departments, and 97 per cent of the population is served. Outstanding progress has also been made in the consolidation of official health agencies locally so that at present only a few cities and very few local school boards attempt to carry on a health program separate from that of the county health department.

I should like to outline for you more completely the establishment and history of each of the separate activities and bureaus of the State Board of Health, but time is not available, except to summarize briefly some of the outstanding improvements that have taken place in public health in the state. In order to illustrate this progress, I direct your attention to table 1 showing the gross death rates during the thirty-one year period 1917-1947. You will note that there has been a steady decline (fig. 1). If the same death

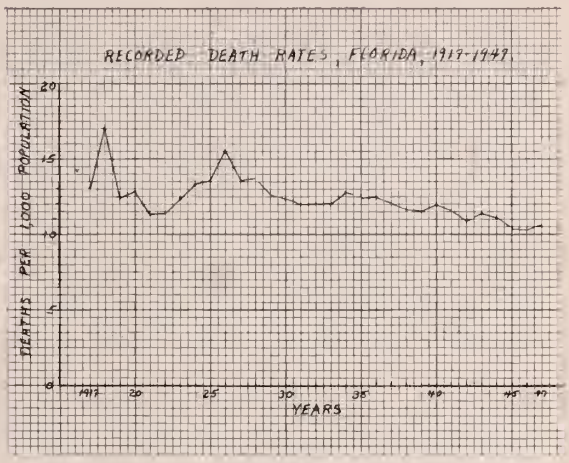


FIGURE 1

rate had prevailed in 1947 as prevailed in 1917, 5,624 more people would have died during the year. This is a definite and substantial saving of human life. In interpreting this chart it should be noted that the 1947 figures are provisional as yet but that the rate shown is somewhat higher than that for 1945 and 1946. It

TABLE 1.—RECORDED DEATHS AND DEATH RATES PER 100,000 POPULATION, FLORIDA, 1917-1947

YEAR	DEATHS FROM ALL CAUSES		INFANT MORTALITY		MATERNAL MORTALITY		TYPHOID		MALARIA		TUBERCULOSIS		DIPHTHERIA		DIARRHEA & ENTERITIS		CANCER		HEART DISEASE	
	Deaths	Rate*	Deaths	Rate**	Deaths	Rate**	Deaths	Rate	Deaths	Rate	Deaths	Rate	Deaths	Rate	Deaths	Rate	Deaths	Rate	Deaths	Rate
1947***	25,417	10.6	2,243	37.0	127	2.1	8	0.3	7	0.3	761	31.6	17	0.7	135	5.6	2,675	111.1	7,187	298.6
1946	24,129	10.3	2,107	38.2	158	2.9	11	0.5	17	0.7	687	29.4	30	1.3	137	5.9	2,598	111.2	6,473	277.0
1945	23,672	10.4	2,097	41.1	146	2.9	15	0.7	22	1.0	701	30.9	29	1.3	252	11.1	2,302	101.6	5,845	257.9
1944	24,453	11.1	2,217	42.9	166	3.2	15	0.7	33	1.5	791	36.0	42	1.9	234	10.7	2,219	101.1	5,797	264.0
1943	24,259	11.4	2,167	44.9	170	3.5	17	0.8	41	1.9	834	39.2	26	1.2	249	11.7	2,064	97.1	5,461	256.9
1942	22,334	10.9	1,947	47.6	168	4.1	26	1.3	48	2.3	859	41.8	28	1.4	234	11.4	1,955	95.1	5,283	257.0
1941	23,125	11.6	1,975	52.6	235	6.3	26	1.3	85	4.3	916	46.1	23	1.2	276	13.9	2,002	100.8	5,502	277.1
1940	22,926	12.0	1,809	53.5	215	6.4	23	1.2	99	5.2	961	50.3	28	1.5	219	11.5	1,829	95.7	5,473	286.2
1939	21,295	11.5	1,821	56.3	209	6.5	27	1.5	112	6.0	921	49.7	33	1.8	304	16.4	1,728	93.2	4,549	245.4
1938	21,023	11.7	1,804	58.0	234	7.5	46	2.6	166	9.2	987	55.0	32	1.8	346	19.3	1,551	86.4	4,377	243.8
1937	20,958	12.1	1,759	59.7	196	6.6	45	2.6	205	11.8	966	55.6	55	3.2	279	16.1	1,622	93.4	4,028	231.9
1936	20,948	12.5	1,664	59.3	216	7.7	39	2.3	349	20.8	905	53.9	57	3.4	263	15.7	1,458	86.9	3,897	232.2
1935	20,047	12.4	1,730	61.7	238	8.5	58	3.6	331	20.4	903	55.7	58	3.6	335	20.7	1,452	89.6	3,476	214.5
1934	20,357	12.8	1,818	68.1	219	8.2	46	2.9	445	28.1	953	60.1	84	5.3	337	21.3	1,325	83.6	3,585	226.1
1933	18,764	12.1	1,619	63.0	285	11.1	63	4.1	373	24.0	1,039	66.9	56	3.6	230	14.8	1,284	82.6	3,053	196.5
1932	18,293	12.0	1,680	61.3	262	9.6	85	5.6	233	15.2	1,093	71.5	83	5.4	272	17.8	1,244	81.4	2,989	195.6
1931	18,101	12.0	1,737	64.3	267	9.9	87	5.8	205	13.6	1,067	70.8	74	4.9	292	19.4	1,072	71.2	2,810	186.6
1930	18,215	12.3	1,729	64.1	267	9.9	72	4.9	332	22.4	1,015	68.6	79	5.3	359	24.3	1,032	69.7	2,789	188.4
1929	18,155	12.7	1,766	65.8	255	9.5	83	5.8	470	32.8	1,014	70.8	67	4.7	355	24.8	994	69.4	2,502	174.8
1928	18,932	13.7	2,000	67.2	280	9.4	121	8.7	388	28.1	1,102	79.7	69	5.0	437	31.6	887	64.1	2,482	179.5
1927	18,143	13.6	2,303	67.6	352	10.3	142	10.6	208	15.6	1,097	82.2	93	7.0	633	47.4	949	71.1	2,290	171.6
1926	20,029	15.6	2,614	75.3	357	10.3	187	14.5	223	17.3	1,187	92.3	123	9.6	682	53.1	878	68.3	2,251	175.1
1925	18,832	13.6	2,179	74.4	330	11.3	187	15.1	209	16.9	999	80.8	105	8.5	620	50.1	776	62.8	2,240	181.1
1924	18,797	13.3	2,182	81.6	284	10.6	157	13.2	249	21.0	1,054	88.7	99	8.3	646	54.4	700	58.9	2,111	177.7
1923	14,074	12.4	1,822	78.5	287	12.4	177	15.5	293	25.7	1,079	94.7	86	7.5	556	48.8	642	56.4	1,761	154.6
1922	12,465	11.4	1,691	77.0	235	10.7	163	14.9	247	22.7	1,019	93.5	95	8.7	496	45.5	538	49.3	1,412	129.5
1921	11,764	11.3	1,770	80.2	230	10.4	186	17.9	231	22.2	951	91.3	69	6.6	577	55.4	496	47.6	1,197	114.9
1920	12,674	12.8	1,835	94.0	181	9.3	140	14.1	352	35.5	1,016	102.3	78	7.9	604	60.8	497	50.1	1,224	123.3
1919	11,830	12.4	1,659	88.9	183	9.8	176	18.4	440	46.0	993	103.7	57	6.0	578	60.4	455	47.5	957	100.0
1918	16,031	17.1	1,947	107.3	174	9.6	255	27.3	224	24.0	1,084	115.9	86	9.2	835	89.3	429	45.9	1,083	115.8
1917	11,992	13.1	1,897	105.9	207	11.6	221	24.2	273	29.9	1,085	118.9	92	10.1	877	96.1	370	41.4	751	82.3

*Rates per 1,000 population.
**Rates per 1,000 live births.
***Provisional figures.

should not surprise us if the gross death rate rises further in the coming years when we consider the increasing percentage of the population that is made up of older people (tables 2 and 3).

TABLE 2.—TOTAL POPULATION AND SELECTED AGE GROUP PER CENTS, FLORIDA, 1910, 1920 1930, 1940

Years	Population	Per Cent 40 Yrs. +	Per Cent 50 Yrs. +
1940	1,897,414	32%	19%
1930	1,468,211	28%	16%
1920	968,470	25%	14%
1910	752,619	20%	11%

TABLE 3.—NUMBER OF EXTRA DEATHS WHICH WOULD HAVE OCCURRED IF THE 1917 DEATH RATES WERE STILL IN EFFECT DURING 1947

Total deaths	6,115
Infant deaths	4,181
Maternal deaths	577
Typhoid fever	574
Malaria	713
Tuberculosis	2,101
Diphtheria	226
Diarrhea and Enteritis	2,178

The graphs showing the steady decline in mortality from malaria, diphtheria, tuberculosis and the enteric diseases and the drop in maternal and infant death rates are gratifying, but we get a different picture when we glance at the death rates for cancer and heart disease (figs. 2-10). Naturally some increase in mortality

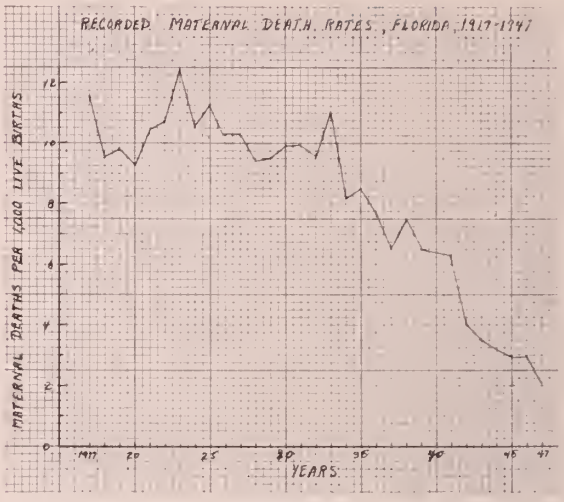


FIGURE 3

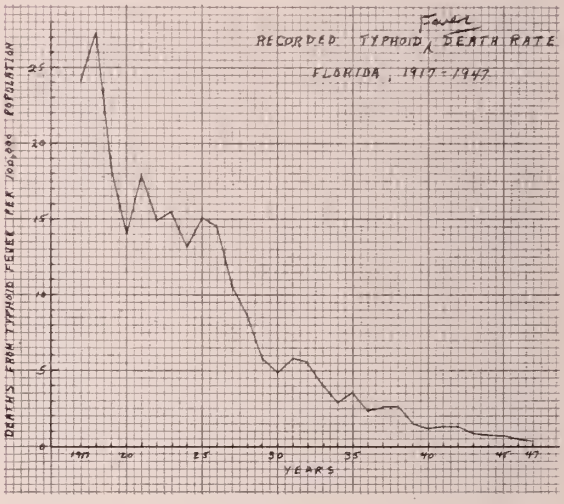


FIGURE 4

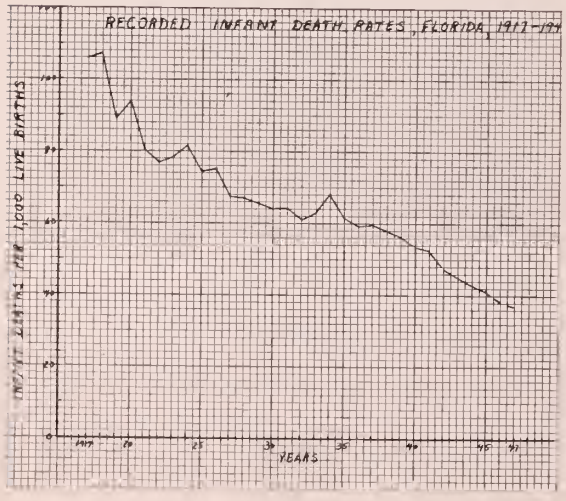


FIGURE 2

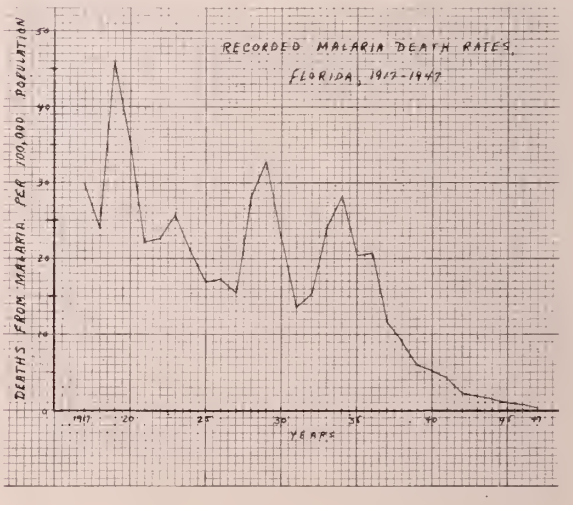


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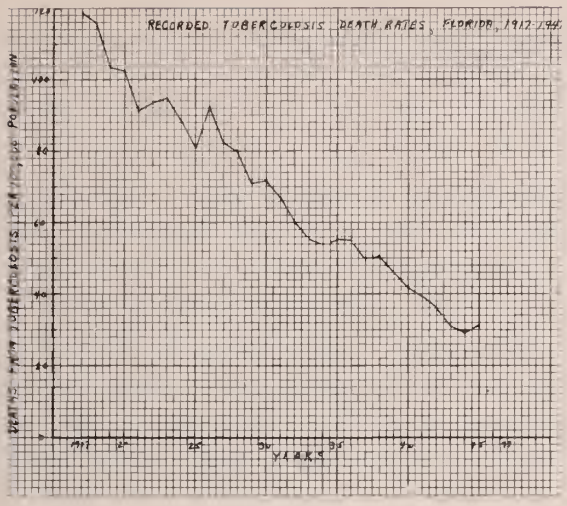


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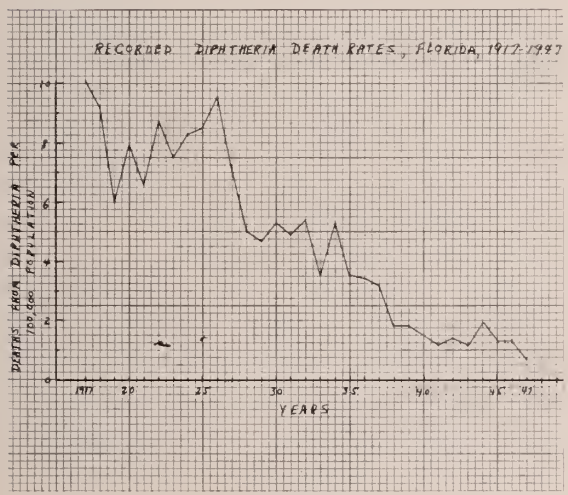


FIGURE 7

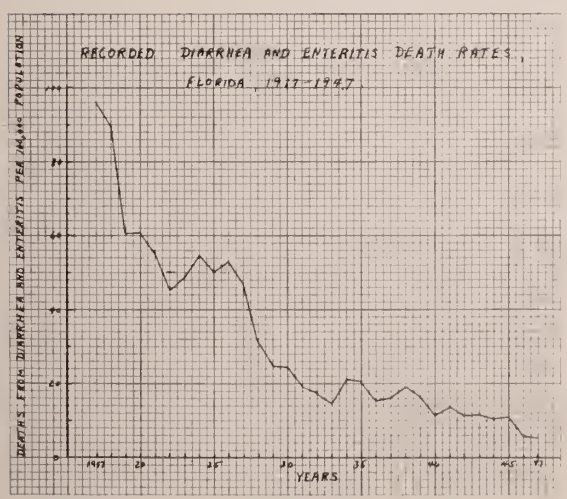


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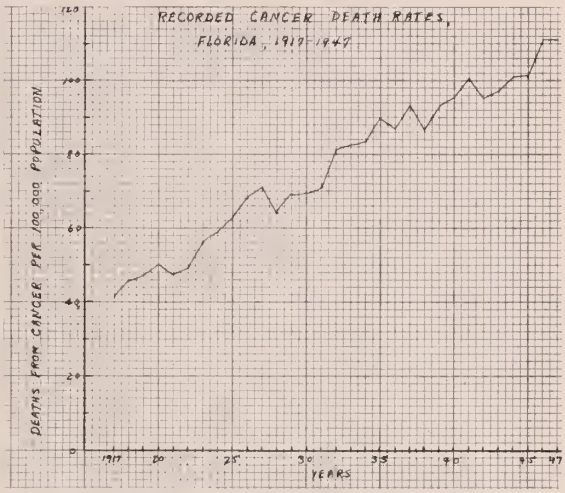


FIGURE 9

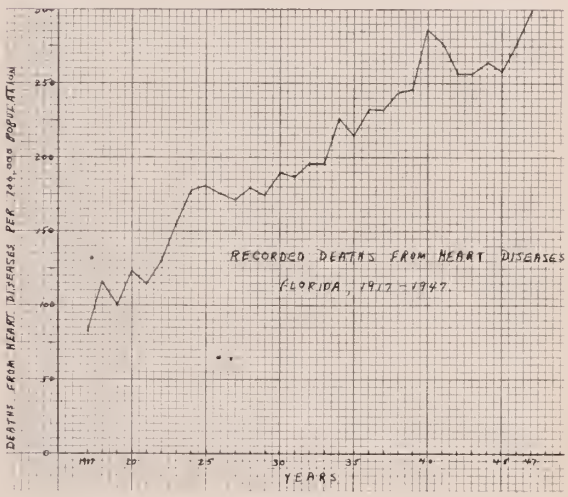


FIGURE 10

from these latter causes is due to the aging of the population, but the amount of increase seems not to be altogether accounted for by this factor.

These graphs and tables, while showing that considerable and substantial progress has been made in the past, point out the need for and the direction of campaigns for the future.

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Volume XXXV
Number 10

Amebiasis and the Proctologist

Ralph F. Allen, M.D.
MIAMI

Amebiasis is a clinical term applied to the syndrome produced by the invasion of the tissues of man by the pathogenic ameba, Endamoeba histolytica. Pathologic change produced by this organism involves, primarily in uncomplicated cases, the mucosa and submucosa of the colon with an occasional invasion of the lower ileum.

It has been shown by numerous surveys made in different regions of the United States that from 8 to 10 per cent of the population is affected with amebiasis. It has also been shown that about one third of the patients harboring this parasite will have lesions located in the rectum and sigmoid. One can estimate then that approximately 800,000 people in the United States have lesions of amebiasis that may be seen on proctoscopic examination. By similar deduction one can assume that in Jacksonville there are approximately 5,700 cases, in Dade County 13,300 cases, in Tampa 3,600 cases and in Orlando 1,200 cases in which lesions of amebiasis are present in the rectum and sigmoid. Thus, it becomes obvious that this disease should be one of extreme interest to physicians doing proctosigmoidoscopic examinations.

Pathologic Manifestations

When the lesions of amebiasis are present and can be seen on proctosigmoidoscopic examination, they are usually so typical in appearance that little doubt is left as to their nature. Craig[1] has emphasized that E. histolytica invades the mucosal epithelium by a lytic action produced by secretions of the ameba. After the amebae have passed through the mucosa and enter the submucosal layer, lysis continues and degenerative changes are produced in these structures. It is in the submucosa that the brunt of the invasion occurs. It is in this layer, also, that degenerative and exudative changes take place without often affecting the muscularis to any degree. The necrotic tissue of the submucosa is thrown off through the small opening in the mucosa, and the typical amebic ulcer is produced.

When seen through the proctoscope, amebic ulcerations appear as rounded, yellowish to grayish, elevated plaques surrounded by a definite halo of fiery red mucosa. The ulcers are usually discrete, and the area of inflamed mucosa surrounding them is sharply demarcated. The mucosa intervening between the ulcerations appears normal. When the yellowish gray accumulation in the center of this ulceration is wiped away with an applicator, the base is seen located beneath the level of the sharply defined, rounded margins. The base usually bleeds profusely, and the ulcer appears as a punched out, sharply defined crater. In no other ulcerative proctitis does one see a picture so typical in appearance.

Many writers have emphasized that amebic ulcers are more apt to appear on the upper surface of the rectal valves. In my experience I have found that amebic ulcers frequently appear in definite clusters or as an individual ulcer located low in the rectum; but, in my cases I have been unable to find a predilection for the upper surfaces of the valves. It appears that the ulceration occurs more frequently on the margin of the valves than at any other location in the rectum.

In fulminating cases of amebic dysentery many bizarre destructive processes may be seen. The entire mucosa of the rectum may be necrotic. Ulcerations may be coalesced to form lesions of great size. Occasionally one of the arteries in the submucosa will be eroded into, and massive bleeding will occur. Various types of fistulae may be produced, and on occasion amebic ulcerations of the perianal skin will appear. This type of lesion is rare and as a rule is seen only in cases of fulminating dysentery.

Diagnosis

How is one to establish a diagnosis of amebiasis? In those cases in which lesions can be demonstrated in the rectum and sigmoid, examination of the contents from the crater of the ulcer should be made. A small amount of the exudate can be collected with a pipet and suspended in saline. This suspension should be examined immediately, and motile trophozoites of E. histolytica will be found. It should be emphasized that on many occasions more than one examination is needed before the amebae can be demonstrated. I have seen cases in which five or six direct smears from lesions were examined before amebae were demonstrated.

If lesions cannot be found within reach of the

Read before the Florida Proctologic Society, First Annual Meeting, St. Augustine, April 11, 1948.

proctosigmoidoscope, one must rely upon examination of the stool. If the stool is liquid and particularly if the stool contains flecks of blood and mucus, the particles containing blood are most likely the portions of the stool in which the ameba will be found. Examination of such a specimen should be made within a few minutes after passage. If the stools are formed, cysts should be looked for. The cysts may be demonstrated in the stool several hours after passage; therefore, in examining formed stools, there is no hurry about completing the examination. All authorities on amebiasis emphasize that the examination of only one stool specimen is not adequate. It has been proved that in about 60 per cent of the cases positive evidence will be missed if only one examination is made; therefore, in our practice my associates and I insist upon at least six stool examinations before we consider the results negative. It has been postulated that amebae are discharged into the lumen of the intestine in showers and, therefore, the feces may be free of amebae one day and loaded with amebae the next day.

Lesions beyond the reach of the proctosigmoidoscope may often be demonstrated by the use of roentgen examination. Lesions in the cecum produce a hyperirritable cecum that is difficult to fill. The moth-eaten appearance of the intestines in the region of the cecum is characteristic of amebic ulceration. Lesions in the ascending, transverse and descending portions of the colon can frequently be seen as a disturbed mucosal pattern and persistent spasm of the wall of the bowel in the region of the ulcerations. The so-called amebic granulomas that are occasionally produced in the cecum and other parts of the colon may be demonstrated as definite polypoid filling defects.

Summary

The pathologic manifestations of E. histolytica are described.

The measures necessary to establish a diagnosis of amebiasis are discussed.

References

1. Craig, C. F.: The Etiology, Diagnosis and Treatment of Amebiasis, Baltimore, Williams and Wilkins, 1944.

805 Huntington Building.

ABSTRACTS OF MEDICAL ARTICLES

AURICULAR FIBRILLATION WITH ABERRATION SIMULATING VENTRICULAR PAROXYSMAL TACHYCARDIA. By James L. Gouaux, M.D., and Richard Ashman, Ph.D., Am. Heart J. 34:366-373 (Sept.) 1947.

The electrocardiographic findings in a case of auricular fibrillation are presented because there occurred periods when the ventricular rate was high, about 200 beats per minute, but with no aberration, and other periods when, with no greater ventricular rate, many successive complexes were of the right bundle branch block type.

After the administration of quinidine sulfate the atrial rate was slowed and the ventricular rate was increased. Numerous aberrant QRS complexes were seen, occurring either singly or in groups of two, three, or more. At several places on the tracings, groups of from six to thirty-three wide, aberrant QRS complexes were seen. At other places, periods of equally rapid ventricular rhythm appeared, but the QRS complexes were narrow. Both when the complexes were wide and when they were narrow, the same slight irregularity in rhythm was found. Reasons are given for believing that the series of wide complexes are due to aberration in the conduction of the supraventricular impulses through the ventricles and that they do not represent ventricular paroxysmal tachycardia, which they closely resemble.

A description is given of the probable mechanism whereby the aberration, once initiated, is maintained.

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The Greatest Delusion of Our Time

Appearing as a guest speaker over the Pettengill hour on the ABC network, Aaron M. Sargent, San Francisco attorney, recently discussed "Socialized Medicine," giving the evidence arranged as an attorney would present a case. The high lights of his address to the radio audience may well be kept before the public by physicians through their wide contacts with the laity. There follow, in substance, some of these details of vivid interest:

This is not a dry subject which concerns only the business of your doctor. Actually, it is your business. It is no longer safe for you to let gullible American liberals, theoretic, impractical, inexperienced people, tinker with that business.

Since Bismarck, the Iron Chancellor, introduced socialized medicine in Germany in 1883, it has consistently failed there and later in France, Great Britain and New Zealand. These failures have certain elements in common. The deficits put a squeeze on both doctor and patient. To avoid excessive cost the state had to limit the amount of service. Pressure was applied to force the doctor to use cheap remedies, even when more expensive treatment was necessary. Some doctors had to see from fifty to a hundred people in a single day. Adequate care was impossible. Since the service was free, the patient had no interest in keeping down the cost, but he had a definite interest in building up a pension claim.

Draft rejection figures for World War II are not an index of our public health. These figures are cited by the Federal Security Agency to prove an emergency and to uphold its contention that the nation's health is in a deplorable state with adequate care possible only under a compulsory system. The truth is that many rejections were for nonmedical causes; others involved conditions which could not have been prevented by any form of medical treatment. Men were eliminated for illiteracy, mental deficiency and insanity, defective hearing or sight and flat feet. Venereal disease was a social rather than a medical problem. Also, examinations were for combat duty.

What of the economic consequences of the proposed compulsory scheme? Group plans and private insurance companies will be eliminated. They are unable to pay the claims that will pile up under a free—get something for nothing—type of law. Health insurance will be a government monopoly. There will be more waste—the result of bureaucracy. In France the cost of social security increased until it consumed twenty-five per cent of the nation's payroll.

The next move will be socialized life insurance, to make it part of the national pension system. Step by step the process will go on. Government invasion of insurance, or of any other business, is like creeping paralysis. It takes over one operation after another until the people have lost control of everything.

Does this thing really affect you, and your future? YOU will find that there is nothing free about free medical care. It is a direct tax on wages. YOU pay the bill. YOU carry the burden of every man who takes advantage of the system. It will reduce your standard of living.

YOU will discover that you have gambled—and lost your opportunity to get real security under voluntary plans. Fifty-two million persons now have some form of hospitalization insurance. Instead of turning over your future to a government bureau, do you not think YOU should arrange for more security by an extension of that system?

There are at least ten communist fronts working for social insurance. Do you think they are trying to improve conditions in the United States? Do you have the idea they are trying to build a strong nation able to stand up against Soviet Russia?

No, the key people in these communist fronts realize that compulsory health insurance will bankrupt the United States, as it has exhausted the finances of every nation which has tried that experiment. They know disorder will follow. They realize that controls established under that system will be available to set up a dictatorship.

Social security is the greatest delusion of our time. We have come to believe we can get security without working for it—that it is only necessary to vote for it. Their belief in that delusion carried the people of another great nation to their destruction. They voted for the promise of a leader who said:

> We shall banish want. We shall banish fear. The essence of National Socialism is human welfare. National socialism is the revolution of the common man. National socialism means a new day of abundance at home, and a better world abroad.

Those are the words of Adolph Hitler, and that is the delusion.

What does America intend to do about its own delusion? What do you propose to do about it?

Understanding What People Are Like

It is heartening to read the prediction from a noteworthy source that while the physical sciences and their applications will continue to thrive in the years ahead, the most significant development of the next century promises to be in the realm of understanding people. Human science, understanding what people are like, is naturally the key to the solution of social problems and obviously will also help in working out many a medical problem.

To understand people, one must know how they are alike and how they differ from one another. Inequalities are doubtless the foundation stone of our democracy. Certainly in every social problem, observed Roger J. Williams,[1] addressing the Centennial Meeting of the American Association for the Advancement of Science, differentiation or individuality is a potent factor. People should, then, be studied psychologically and in their social relations as well as anatomically and physiologically, he concluded. If all were alike, there would be no need for the freedom on which rests our democratic way of life. It is individuality that gives rise to the demand for freedom to make one's own decisions and to live one's own life. Likewise, it is individuality that makes the doctor-patient relationship so sacred and the preservation of the freedom of the medical profession from the ruin of regimentation so vital.

In man, inherent individuality is most highly developed, and superimposed upon it are the differences arising from environmental and cultural influences. The relative importance of these two factors has long been and doubtless will long remain a matter of conjecture. Nevertheless, when one considers individual variation in the shape and size of the body in general and of the head, nose, hands, feet and legs, as well as in the shape, size and cellular composition of the thyroid, adrenals, sex glands and pituitary glands, it is not reasonable to expect the senses to work uniformly for all.[1]

It has been established that people inherit through the agency of genes their entire metabolic machinery. Since each inheritance is distinctive, individual metabolic machinery is likewise distinctive. The existence of allergies and differences in the response to drugs is an outward manifestation which illustrates well the existence of distinctive metabolic patterns.

Too, Williams pointed out, intelligence is not a unitary trait possessed in high degree by some and in low degree by others. Fortunately, there are many different ways in which one can be intelligent.

Recognition of and care for individuality will feature the revised school system of the future in the opinion of this authority. Considerable effort in the earliest grades devoted to helping students become acquainted with themselves will in due time have telling effect socially. Also, it should aid materially in the solution of medical problems now hampered by too little cognizance of human science on the part of the physician and too little intelligent understanding and cooperation on the part of the patient.

1. "Understanding People," editorial, J. A. M. A. 138:892 (Nov. 20) 1948.

Isla Bonita Plantation Wartime Cinchona Drama Ends

Isla Bonita suggests tranquil beauty and peaceful repose, but behind the name lies the little known drama of a medical Pearl Harbor of World War II on which the government has now rung down the curtain. The drama opened in the Philippines and ended in Costa Rica. It illustrates the consequences of unpreparedness in alternative sources of supply for vital drugs in time of war.

When Gen. Douglas MacArthur realized that the United States would have to fight a long war in the malaria-infested Pacific, he knew that quinine from the cinchona trees of the Pacific islands, chief source of the world's supply, would be cut off. As the fall of Bataan became imminent, he ordered Col. Arthur Fischer, a reserve officer long in forestry work in the Philippines, to gather as many cinchona seeds as possible from the experimental plantation he had established years before.

Colonel Fischer succeeded in getting to the plantation and sorting out seeds of his best strains of cinchona. Spotted by a Japanese airplane, he hastily dumped the seeds into a bag and made his way back to Bataan. A few days later, he and about five pounds of the cinchona seeds left the Philippines for Australia by submarine with General MacArthur.

Soon the seeds were in carefully controlled storage in Washington, and Colonel Fischer set out with a soils expert to find a suitable plantation site. In Costa Rica, about twenty miles north of San Jose, they found what appeared to be an ideal location.

Clearing the jungle, building an access road, developing the plantation took time, much time, despite all possible haste. With 400 acres cleared and buildings and equipment ready, the project was christened "Isla Bonita Plantation." Progress was fairly encouraging until a disease caused by an unsuspected infection in the soil attacked the roots of the trees. A good many trees survived the root infection, and bark from some of them proved to be high in quinine content. But large scale production was not attained. And then the war was ended.

Now the United States government has turned the 4,320 acre tract and its equipment over to the Costa Rican government. Stock from Isla Bonita will be used for experiments, which may produce lasting results for Colonel Fischer's efforts after all. But with the wartime plans for big production of cinchona at Isla Bonita dead, will the government complacently look to the Pacific Isles again as the main source of supply, or will Isla Bonita teach the lesson of long range preparedness in the Western Hemisphere?

Patients Versus Cases

One of the grand old men of medicine was quoted in the lay press recently as suggesting that it would be a good thing if the young graduates in medicine were trained to think of patients as patients and not as cases. This savant opined that several phenomena suggest the current pattern of medical teaching has gone overboard in attempting to make things look scientific, and he deplored the tendency to look to the laboratory for clews in diagnosis in default of clinical observation and diagnostic acumen.

The great strides in scientific achievements in recent years are a matter of pride to the profession, and their place in medicine is certainly not to be discounted in the slightest degree. In view of this criticism, however, it is gratifying to observe that perhaps somewhat belatedly but nevertheless definitely, the patient as such is now coming into his own. In the immediate past psychosomatic medicine has somewhat suddenly become the vogue, and its influence has pervaded not only the specialty of general practice but the other specialties as well. The whole patient is considered, not merely his disease; the various aspects of his case are focused on him, not as a case number but as an individual. The spotlight is on him in the light of his disease of course, but also on him as a personality whose reactions physically and mentally are distinctly peculiar to him.

Paramount with the physician professionally abreast of the present trend is the whole patient with his characteristic traits and special problems as well as his particular ailment. Each patient becomes an individual study, fascinating in diversity. Training in this respect is a great asset to the young physician and offers great advantage in the practice of his profession to the medical student of the future. Reversal of this commendable trend would no doubt be one of the many deplorable fruits of the regimentation of medicine.

The Physician and the Body Politic

The physician has a tremendous obligation as a citizen. Today especially, with the very life of a free profession at stake, interest in public affairs is a major responsibility of every practitioner of medicine.

Patience, understanding and perseverance are practically always an important part of the armamentarium of the successful physician. These are traits admirably suited to the role of statesman or politician, and all too often lacking. Physicians are peculiarly fitted to minister to a sick society for the very nature of their profession gives them opportunity to understand human relations and to know human needs as well or better than any other group in our society. Too, their patients and friends and their wide contacts constitute an extraordinary political potential, much too seldom used.

In the Eightieth Congress there were seven physicians in the House of Representatives and none in the Senate. Of these seven, all were re-elected last November. Four are Republicans, and three are Democrats. Not one is from the South. They represent the states of Pennsylvania (2), Minnesota, Nebraska, Ohio, West Virginia and New York.

In former years more physicians were distinguished in public life than today. The Declaration of Independence bears the signatures of six members of the medical profession, and three signed the Constitution of the United States. Across the years, the pages of history are dotted with the names of physicians here and abroad who have distinguished themselves in political roles. As recently as some two decades ago, two past presidents of the American Medical Association held cabinet posts. Doubtless the steadily increasing exactions and time-consuming demands of their profession account in some measure for the lack of political activity among men of medicine in the immediate past and at the present time.

Democracy functions, of course, through politics, and the guiding hand of able physicians in the political affairs of this nation at this time is a crying need. Wisely enough, the distinguished statesman-physician, Congressman Walter H. Judd, has stressed the need in Washington of "more doctors in government and, above all, more of the kind of mental habits that good doctors must have."

The Nemours Foundation and Its Program for the Crippled Children of Florida

A. R. SHANDS, JR., M.D.
WILMINGTON, DEL.

It has been thought that at this time a brief statement should be made to the physicians of Florida concerning the Nemours Foundation and its program for crippled children, in order that they may understand what the plan is for helping Florida children. With this thought in mind, as medical director of the Foundation I have prepared the following statement:

Mr. Alfred I. du Pont died on April 29, 1935 in Jacksonville and had been for many years prior to this date a legal resident of the state of Florida. Under the terms of his will the Nemours Foundation for the care and treatment of crippled children was established on Sept. 2, 1936, being legally incorporated under the laws of this state. On March 5, 1937 the trustees of the Alfred I. du Pont Estate, of which Mrs. Alfred I. du Pont is president, invited eight nationally recognized doctors to meet at Mrs. du Pont's home "Epping Forest" in Jacksonville to plan a program for crippled children. These doctors, five of whom were orthopedic surgeons, were appointed to serve as a Medical Advisory Board to the Foundation. Under the will it was directed that a hospital be built in Wilmington, Del., within the grounds of Mr. du Pont's home. After three years of planning and building, this was opened on July 1, 1940. It is called the Alfred I. du Pont Institute. It contains facilities for hospitalization and academic education of crippled children and laboratory facilities for research on problems related to the crippled child. This Institute has now examined and cared for over 2,500 children.

Since the incorporation of the Foundation it has been in the minds of the trustees that at some future date assistance would be rendered to the crippled children of Florida. In 1946 plans were made to start a program for Florida children. But for the war years this program would have been started before this time. It was thought first that it might be possible to render substantial aid to Florida children through hospitalization in the Alfred I. du Pont Institute in Wilmington. This idea was discussed in March 1947 with Dr. L. J. Graves, Acting Director of the Florida Crippled Children's Commission, and he was informed that

Medical Director of the Nemours Foundation, Jacksonville, Fla., and Wilmington, Del.

the Institute would accept Florida children and if necessary designate a minimum of ten beds to these patients. Over a period of two years following this time a few Florida children were sent to Wilmington. It was found that because of the distance this plan was not practical and would not result in giving real assistance to Florida crippled children. It was then decided by Mrs. du Pont and the trustees that direct aid should be given in the state. The question arose how best could this be done. During the first part of 1948 the medical director of the Foundation visited all of the hospitals and homes in the state caring for crippled children, talked with the orthopedic surgeons, superintendents and many board members of these institutions and visited representatives of many other agencies operating a crippled children's program. He also had one conference in April 1948 with the acting director, his secretary and two members of the Crippled Children's Commission and the five senior orthopedic surgeons in the state program. These visits and conferences resulted in the acquisition of a great deal of information concerning the programs and finances of the agencies which made it evident that the greatest immediate need was to provide funds to make it possible for additional children to be admitted into the present institutions as there were empty beds, long waiting lists and insufficient funds to provide the necessary hospitalization. Having decided on this plan for direct aid, it became evident that the Nemours Foundation funds would go further if they were channeled through an existing agency. The Crippled Children's Commission was selected and kindly consented to administer this fund. The Commission was informed that as of Oct. 1, 1948 the Nemours Foundation would pay within the limits of a specified budget ($30,000) for the hospitalization and convalescent home care of those children under 16 years of age who were not suffering from infantile paralysis or cerebral palsy. Otherwise the definition of the crippled child which had been accepted by the Florida Crippled Children's Commission was accepted by the Foundation. During the first four months of this program, the Nemours Foundation has paid for the hospitalization and convalescent home care of 36 children. It is estimated that the available funds for 1948-1949 will make it possible for approximately 100 crippled children to be given institutional treatment who otherwise would not be able to receive hospital and convalescent home care during this period.

After the many conferences and discussions during the last two years, it was the opinion of the medical director that one of the greatest immediate needs for Florida was a meeting in which representatives of all crippled children's agencies could get together and discuss their common problems, as it appeared that some agencies were not fully cognizant of what others were doing. With this thought in mind the medical director talked with Mr. Marcus C. Fagg and Mrs. Sylvia Carothers of the Florida Children's Commission and then requested the Florida Children's Commission to call a Conference on Services to Crippled Children. This conference was held in Jacksonville on Feb. 4 and 5, 1949 and was attended by approximately 100 persons representing the Florida institutions, agencies and societies interested in the problems of the crippled child. Many pediatricians, orthopedic surgeons, public health officers and other physicians were in attendance. As a result of this meeting many recommendations will be made for the coordination and improvement of the services for the crippled child in the state.

It is hoped that this initial program of private philanthropy will be the beginning of a real and worth while service by the Nemours Foundation to the crippled children of Florida.

Dr. Lischkoff Receives 1948 Civic Award

Dr. M. A. Lischkoff of Pensacola was the recipient of the 1948 award for outstanding, unremunerated public service presented annually by the Kiwanis Club of that city. A past president of the club, he was the fifth Kiwanian chosen for this honor in the twenty-seven years of the award, and it was pointed out that Kiwanians must stand out above all others to receive this trophy from their own club. Presentation was made at the annual banquet in January, and in the absence of Dr. Lischkoff, who was in Miami attending the Midwinter Seminar in Ophthalmology and Otolaryngology, Miss Marion Lischkoff accepted for her father the handsome silver vegetable dish which was the award.

His efforts in the organization of the Escambia General Hospital won for Dr. Lischkoff this recognition. He was cited for initiating and pushing to completion this project and also for his public service over a long period of years during which

he, "retiring because of his nature and his profession, . . .has worked quietly and untiringly on several projects for the betterment of his community."

Early in 1947, Dr. Lischkoff proposed as a Kiwanis project the conversion of the decommissioned Escambia Tuberculosis Sanatorium into a county hospital. At his instigation it became the objective of the club and also of the Escambia County Medical Society, whose entire membership worked unceasingly for its success. Other civic groups and the Board of County Commissioners aided generously. Hearty community cooperation soon made possible successful consummation of the project when the hospital went into full operation on Oct. 4, 1948, exactly one year after the five trustees appointed by Governor Caldwell had organized with Dr. Lischkoff as chairman.

The hospital is a general hospital with seventy-eight beds, an outpatient department, a unit for contagious diseases and a wide variety of medical and surgical facilities. Four beds are reserved for mental patients, who are handled as transients. The various units, both for white and Negro patients, are all connected by covered ramps.

A long-felt need in the community, the hospital gives excellent service to indigent and part pay patients and also to private patients. It has the recognition of the American Medical Association and stands as a worthy monument to civic enterprise fostered under the able leadership of Dr. Lischkoff.

Urological Post Graduate Seminar

The American Urological Association through its Southeastern Section announces a Urological Post Graduate Seminar to be held in New Orleans for four full days, beginning on Monday, April 18, and continuing through Thursday, April 21, 1949. The Seminar will be conducted under the auspices of the Division of Graduate Medicine, Tulane University School of Medicine, with Dr. William D. Frye, Dean of the Graduate School of Medicine, directing the courses in collaboration with the officers and executive committee of the Southeastern Section and the representative of the Central Committee.

This first Seminar to be presented by the Southeastern Section is designed especially for young urologists, urological residents, surgical interns especially interested in urology, and physicians and surgeons doing diagnostic urology (part time). While it will be of particular value to those preparing for examination by the American Board of Urology, it will also afford an excellent review for all urologists.

Experienced urological teachers will lecture on Anatomy, Embryology, Pathology, Physiology, Biochemistry, Endocrinology and Bacteriology, presenting their subjects in an illustrated and attractive manner. Operative Urological Clinics will be provided on the various services of the hospitals for those who wish to stay over Friday, April 22.

The courses will be limited to 150 registrants. The cost will be $50 to all except residents in urology. Early application is recommended in view of the wide interest already expressed by members of the Section. Inquiries and applications may be sent to Wm. W. Frye, M.D., Dean, Graduate School of Medicine, Tulane University, New Orleans. Also, Dr. W. L. Fitzgerald of Miami, Florida's representative on the executive committee of the Seminar, will be glad to receive communications concerning the course.

Midwinter Seminar in Ophthalmology and Otolaryngology

A select group of physicians from over the nation attended the Midwinter Seminar in Ophthalmology and Otolaryngology held at the Robert Richter Hotel in Miami Beach, January 10-15, 1949. Sponsored annually by the Graduate School of Medicine of the University of Florida, the Seminar this year attracted registrants from 40 states and 3 foreign countries.

During the first three days lectures on ophthalmology were presented by the following distinguished medical teachers: Dr. John H. Dunnington, Professor of Ophthalmology at Columbia University College of Physicians and Surgeons and Director of the Eye Institute at the Presbyterian Hospital in New York; Dr. Avery Prangen of the Mayo Clinic in Rochester, Minn.; Dr. Georgiana Theobald, Clinical Pathologist and Professor of Ophthalmology at the University of Illinois College of Medicine in Chicago; Dr. Derrick Vail, Professor of Ophthalmology at Northwestern University Medical School and Editor of the American Journal of Ophthalmology, also of Chicago; and Dr. Alan C. Woods, Director of the Wilmer Eye Institute at the Johns Hopkins University School

of Medicine in Baltimore.

Noted otolaryngologists lecturing on the last three days were Dr. A. C. Furstenberg, Dean and Professor of Otolaryngology at the University of Michigan Medical School in Ann Arbor; Dr. Paul H. Holinger, Professor of Bronchoesophagology at the University of Illinois College of Medicine in Chicago; Dr. John R. Lindsay, Professor of Otolaryngology at Northwestern University Medical School in Chicago; Dr. Philip E. Meltzer of the Department of Otolaryngology at the Harvard Medical School in Boston; and Dr. LeRoy Allen Schall, Professor of Otolaryngology at the Harvard Medical School in Boston.

Whitaker & Baxter Release

The following release has been received from Whitaker & Baxter, campaign directors, National Education Campaign, American Medical Association:

Immediate Release

In a sharply-worded statement, commenting on Washington news reports that the Federal Administration plans to launch anti-trust prosecutions against several State Medical Societies, concurrent with the opening of its drive for compulsory health insurance, the American Medical Association today announced that "We will take our case directly to the American people if we find the Government is engaged in political persecution instead of legitimate prosecution."

Dr. Elmer L. Henderson, Chairman of the Board of Trustees of the American Medical Association, declared:

"The American people will not take kindly to Gestapo activities and the doctors of this country, when the health of their patients and the welfare of their profession are at issue, will not be frightened into non-resistance by threats against them.

"We have been making our own inquiry into the activities of Government investigators and if we find that an attempt is being made to use the Justice Department for political purposes, in an effort to stifle opposition to the socialization of medicine, we will air the facts to the people and demand a Congressional investigation into such activities.

"It is both false and absurd to imply that there is a monopoly in health insurance under the hundreds of voluntary systems operating in America today, with more than 52,000,000 insured members. But there certainly would be an iron-clad monopoly if Patent Medicine Man Oscar Ewing got through his compulsory health insurance scheme and took over control of medical practice in this country.

"The American Medical Association is vigorously supporting all sound voluntary health insurance systems and is encouraging competition, between the pre-paid medical and hospital plans and the private insurance indemnity companies, because we believe the American people will get better coverage, at a better price, if many competing plans are available. We don't believe the people want a Government monopoly in the health insurance field, any more than they would condone a private monopoly, and we intend to fight the Government monopoly, proposed under compulsory health insurance legislation, even if the Federal Administration resorts to terroristic practices and witch-hunting in an attempt to frighten off opposition."

STATE BOARD OF HEALTH

Cancer Control Program

The number of applications for aid to indigent persons under the Cancer Control Program has steadily increased up to the present time, and more and more persons each month have been furnished medical care and hospitalization under the plan.

It now appears that Cancer Funds are not sufficient to continue the program at its present rate between now and July 1 when a new appropriation will be available. Until February 1 the maximum fees provided for by the fee schedules have been paid for professional services. Because of the shortage of funds, and in order to provide for as many indigent persons as possible and in order to spread available funds equitably among physicians rendering professional services to cancer patients, it will be necessary to reduce such fees paid between now and July 1. This is a temporary and necessary expedient and we believe that the physicians of the state will accept this temporary arrangement as it appears to be the only one possible under the circumstances.

Reporting of Influenza

The Surgeon Generals of the United States Army, Navy, Air Force and Public Health Service have developed a plan for the establishment of an Influenza Information Center at the National Institutes of Health at Bethesda, Md. This center will administer in this country the World Health Organization Influenza Program whose aim is the protection of the people of the world from a pandemic of influenza as last experienced in 1918.

The Information Center will collect information as to the occurrence of an outbreak of suspected influenza, and aid in the isolation of the virus as a means of determining the prevailing strains for use in the production of vaccine.

Local health departments and the physicians of the state have a definite part to play in this program since it is they who first will have knowledge of local outbreaks of suspected influenza.

It is, therefore, requested that physicians will report the occurrence of influenza in your practice, using as the criteria for diagnosis the "typical" clinical features: sudden onset of fever, muscular aching, prostration, and varying degrees of inflammation of the respiratory tract.

Upon the resignation of Dr. Rollin D. Thompson, Medical Director of the Florida Tuberculosis Sanatoria, Mr. W. T. Edwards, chairman of the

Tuberculosis Board, requested that Dr. Clarence M. Sharp be allowed to assist them because of their lack of a medical director. The State Board of Health has agreed to lend Dr. Sharp to the Tuberculosis Board on a part time basis until a successor to Dr. Thompson can be appointed. Dr. Sharp therefore is in charge of tuberculosis activities for both the State Board of Health and the Tuberculosis Board, which operates the Sanatoria in Tampa, Orlando and Marianna.

CORRESPONDENCE

Postgraduate Short Course

January 28, 1949

To the Editor:

Because there may be some dissension among the South Florida doctors with reference to the Postgraduate Short Course being held in Jacksonville again this year, and since I am a member of the Committee on Medical Postgraduate Course and am from Northwest Florida, I should like to make a plea and give some reasons why I think this city is the logical, practical and fair location.

I am under the impression that in the beginning when the Short Course was initiated it was designed primarily for the benefit of the general practitioner. I believe in this section of Florida there are more underprivileged general practitioners per capita than in other parts, especially with regard to opportunities for postgraduate instruction and knowledge. A great many of the doctors in this section have to do real general practice, that is, everything from bedside diagnosis and treatment to major surgery without too many facilities. They oftentimes have to do much riding to serve the people as the miles are many and the practice heavy. There are but few specialists to whom they can refer their patients and these specialists are not easily accessible. They have to be the family doctor and the specialists in many, many cases. The hospital facilities in this section are not plentiful and not accessible. There are but few opportunities to attend clinicopathologic conferences or even hospital staff conferences, and organized medical societies are relatively few.

The demand for their services prevents these practitioners from taking postgraduate work in the bigger centers, to say nothing of their financial situation and economic status. They have to depend on reading journals and studying books to keep abreast, in a small way, of the present tempo of advancing scientific medicine and surgery. There are very, very few medical conventions of any size or caliber held in this section of the state as our cities are too small to accommodate such gatherings. For the general practitioner of medicine in this section to get postgraduate instructions he has to go to extremes. He must have ambition and a keen desire to learn and improve if he makes the effort, and too often he passes up the opportunity merely because it is not easily or practically accessible. It may be true that too few Northwest Florida doctors attend the Postgraduate Short Course, but I believe as more interest and emphasis are placed on this opportuunity, they will take more and more advantage of it, for the time has arrived when doctors in general will take more interest and pride in their profession both from a dignified as well as an educational standpoint. With professional competition from colleagues and contemporaries, cults and governmental bureaus, doctors will equip themselves accordingly. They deserve and should have the facilities at their disposal or readily accessible.

I believe the South Florida doctors have more opportunities at their command and they should not be adverse to our having the one and only real institution for postgraduate training easily accessible. If the opportunity is removed from us, we will become more lethargic in our efforts and less informed on medicine, and both we ourselves and our people will suffer in consequence. Naturally I am biased on the subject because of my location, but this plea is not for me individually. I am interested in all Florida doctors and Florida medicine in general; I want to see that the doctors of Florida have as nearly as possible equal opportunity.

I appreciate and respect my position on the Short Course committee, and to voice my opinion is nothing more than I consider my privilege. I will do my best to work on and with this committee to the best advantage of Florida doctors as I see it, and I will not lend my efforts to accommodate one or just a few concerned. I hope this letter will be received with the same interest and in the same spirit in which it is sent. You may use any part of this letter for any purpose you may choose, for it is intended to try to prevent any animosity or ill feelings in our great professional Association.

Sincerely yours,

(Signed) W. C. Roberts, M.D., Member Committee on Medical Postgraduate Course

Panama City, Fla.

STATE NEWS ITEMS

Dr. Nelson A. Murray of Jacksonville was the speaker at a February meeting of the Kiwanis Club. Dr. Murray entitled his talk, "Magic Bullets," and referred to numerous discoveries in the arts and sciences by that name as he touched upon the remarkable progress made in medicine during the past seventy-five years.

Dr. Samuel R. Norris of Jacksonville was the presiding officer at sessions of the South Atlantic Association of Obstetricians and Gynecologists which were held in Williamsburg, Va., in February.

Dr. Duncan T. McEwan of Orlando spoke before members of the local Rotary Club in January. He spoke on the socialization of medicine, pointing out the evils such a plan would initiate in this country.

Dr. Joseph R. Carver has opened offices for the practice of medicine in Branford. He formerly practiced in Dalton, Ga.

Dr. John N. Moore of Ocala has been reappointed chairman of the State Executive Committee, Florida Division, American Cancer Society. Dr. Moore has been chairman of the committee since 1944.

Dr. Richard C. Cumming of Ocala recently was honored by the North Florida Council of the Boy Scouts of America for his outstanding work in Boy Scout activities.

Dr. Sullivan G. Bedell of Jacksonville recently was a guest speaker at a meeting of the Woman's Club of South Jacksonville.

Dr. Lydia A. DeVilbiss of Miami was a guest at the February meeting of the Monroe County Medical Society. While in Key West, Dr. DeVilbiss is residing at 123 Ann Street.

Dr. Wilbur C. Sumner of Jacksonville has returned to his practice after a year's study at the Memorial Hospital in New York City.

Dr. Lillian C. Mark has returned to Jacksonville from New York City where she attended several clinics.

BIRTHS, MARRIAGES AND DEATHS

Births

Dr. and Mrs. Talmadge S. Thompson, Venice, announce the birth of a son, Stanley Warren, on Jan. 16, 1949.

Dr. and Mrs. A. Mackenzie Manson, Jacksonville, announce the birth of a son, Alexander Mackenzie, Jr., on Jan. 30, 1949.

Dr. and Mrs. J. K. David, Jr., Jacksonville, announce the birth of a son, Richard Joseph, on Jan. 29, 1949.

Dr. and Mrs. Sidney Stillman, Jacksonville, announce the birth of a daughter, Susan Melinda, on Jan. 28, 1949.

Dr. and Mrs. Henry L. Smith, Jr., Jacksonville, announce the birth of a daughter on Jan. 1, 1949.

Dr. and Mrs. Webster Merritt, Jacksonville, announce the birth of a son, John Webster Merritt, II, on March 11, 1949.

Marriages

Dr. Willard R. Gatling of Jacksonville and Miss Jane Stevens Lindsay of Jacksonville were married on Dec. 26, 1948.

Dr. David Kirsh of Miami and Miss Athelda Gladstone of Birmingham, Ala., were married on Dec. 25, 1948.

Deaths — Members

Harold A. Ryan, Miami Beach ... Feb. 25, 1949

LAB TECHNICIAN, former Florida resident, wishes to return; 14 years' experience, including hospital, board of health labs, bacteriology, general work and 4 years Army; age 35, male, married. For further information write W. J. Evans, Box 710, Amarillo, Tex.

WANTED: Practicing physician; Florida license not required. For further information write Clinical Director, Florida State Hospital, Box 189, Arcadia, Fla.

FOR SALE: General practice, including equipment. Central downtown location in beautiful Sunshine City of St. Petersburg, Fla.; population, 100,000. Price, $5,000; easy terms. Leaving June 15 to accept residency. Will introduce. Write P. O. Box 658, Station A, St. Petersburg, Fla.

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Errata

On page 46 of the 1949 Florida Medical Directory at the end of the second column under the caption "Orlando", "Florida Sanitarium+" is shown. The "+" should be deleted and under "Cen. Fla. State San." the "+" should be shown.

The Cen. Fla. State San. should be shown approved by the American College of Surgeons and the Florida Sanitarium should not be shown as approved.

According to F. R. Arestad, M.D., of the A.M.A., the symbol was erroneously applied in the Journal A.M.A., August 14, 1948.

Medical Licenses Granted

Dr. Frank D. Gray, Secretary of the State Board of Medical Examiners, has reported that of the 158 applicants who took the examination of the Board, held November 29-30, in Jacksonville, 140 passed and have been issued licenses to practice medicine in Florida. The names and addresses of the 140 successful applicants follow:

Alford, Samuel Jackson, Jr., Jacksonville (Coll. Med. Evangelists 1948)

Alspach, Walter Louis, Miami (U. of Buffalo 1918)

Andrews, Phyllis Jane, Miami (Yale 1948)

Aten, William Goranflo, Miami (Northwestern 1943)

Barrett, Jack William, Miami (St. Louis Univ. 1946)

Barry, Carey Neilson, Clearwater (Duke 1948)

Batell, Leo, Tampa (New York Univ. 1923)

Behrens, Paul R., New York, N. Y. (Middlesex 1946)

Bell, Alan Eddy, Seattle, Wash. (Johns Hopkins 1945)

Belott, Joseph Adolph, Daytona Beach (N. Y. Univ. & Bellevue Hosp. Med. 1910)

Benenson, William, Flushing, N. Y. (Cornell 1929)

Berger, Robert Lawrence, Chappaqua, N. Y. (Middlesex 1945)

Bird, Cornelius Ashley, Decatur, Ga. (Emory 1941)

Boese, Herman Lamar, Ft. Lauderdale (Tulane 1947)

Boles, Truett Claude, Miami (U. of Texas 1948)

Borovsky, Maxwell Philip, Chicago, Ill. (Rush Med. Coll. 1920)

Bowes, Roy R., Madison College, Tenn. (Coll. Med. Evangelists 1943)

Brill, Thomas Mortensen, Gainesville (Univ. of Mich. 1944)

Brooks, Thos. Joseph, Jr., Tallahassee (Bowman Gray 1945)

Brown, Edwin Wells, West Palm Beach (Duke 1941)

Burkhardt, Hans Emerson, Ocean City, N. J. (Temple 1941)

Carpousis, Aris, Eglin Field (Hahnemann Medical 1946)

Carswell, Bowdre Lucian, Attapulgus, Ga. (University of Georgia 1948)

Childs, Lansing Gamaliel, Gainesville (Meharry Medical Coll. 1947)

Cornille, Alfred Joseph, Chicago, Ill. (Loyola University 1942)

Counts, Russell L., Chattanooga, Tenn. (University of Georgia 1947)

Crasson, Joseph Kenneth, Coral Gables (L. I. Coll. of Med. 1947)

Curtin, Leo Vincent, New York, N. Y. (Coll. of Phy. & Surg., Boston 1943)

Cushman, Robert Gale, Jacksonville (Bowman-Gray 1946)

Cusumano, Aurelius, New York, N. Y. (Middlesex 1945)

Dexter, Helen Louise Taylor, Clearwater (Columbia U. Coll. of Phy. & Surg. 1937)

Dexter, Morris William, Cincinnati, Ohio (U. of Cincinnati 1942)

DiCosola, Michael Angelo, St. Petersburg (Loyola Univ. 1943)

Dornberger, George Raymond, Rochester, Minn. (Univ. of Neb. 1938)

Dudley, Ervin Frank, Okeechobee (Hahnemann Med. 1912)

Duff, Oliver Adkins, Birmingham, Ala. (Tulane 1945)

Duke, James Roncie, Tampa (Johns Hopkins 1948)

Dunn, Seymour, Brooklyn, N. Y. (Middlesex 1946)

East, William James, Lake City (Ohio 1941)

Eiben, Robert Michael, Cleveland, Ohio (Western Reserve 1946)

Ernst, Marie Katherine, Tampa (Albany Med. Coll. 1948)

Fecher, Mark Patrick, Jacksonville (St. Louis 1946)

Feldman, Leon Ralph, New York, N. Y. (Middlesex 1945)

Ferguson, Wm. Bernard, Miami (Indiana Univ. 1942)

Foley, Joseph Dayton, Salisbury, Md. (Coll. Med. Evangelists 1947)

Frishkorn, Paul Elliott, St. Petersburg (Univ. of Cincinnati 1947)

Furnas, Aubrey Robert, Jacksonville (Indiana Univ. 1948)

Garcia, Servando Caesar, New Orleans, La. (La. Sch. Med. 1945)

Gasque, MacRay, Fontana Dam, N. C. (University of Virginia 1944)

Goldsmith, Maximilian Orfevre, Miami Beach (Chicago Med. Sch. 1943)

Grau, Sidney, St. Petersburg (Ohio State U. 1943)

Guiteras, George Gustavo, San Antonio, Texas (Univ. of Pa. 1931)

Hammond, Merton Leonard, Panama City (Univ. of Md. 1942)

Haney, Taswell Paul, St. Petersburg (University of Virginia 1926)

Hanson, James Robert, Miami (Northwestern 1947)

Hedrick, Donald W., Detroit, Mich. (U. of Michigan 1928)

Herndon, Benj. Eugene, Tampa (Coll. Med. Evangelists 1946)

Hershey, Harry, Jersey City, N. J. (State U. of Iowa 1937)

Hodge, Leonard, Miami (Med. Coll. of Alabama 1947)

Howard, Frank Davis, Leesburg (Univ. of Tenn. 1948)

Hughes, Paul William, Gainesville (Boston Coll. of Phys. & Surg. 1944)

Johnson, Ernest Cleveland, Jr., Savannah, Ga. (Boston Coll. of Phys. & Surg. 1943)

Johnstone, Robert Henry, Chicago, Ill. (Rush Med. Coll. 1924)

Karowe, Harris Elliott, Miami (Columbia U. Coll. of Phys. & Surg. 1947)

Kroll, Peter Gregory, Orlando (Med. Coll. State of S. C. 1933)

Laipply, Thomas Charles, Chicago, Ill. (Western Reserve 1936)

Landes, John Shriner, Cleveland, Ohio (Western Reserve 1942)

Lansman, Wilfred, Astoria, N. Y. (Middlesex 1945)

Larson, Gerald Edwin, Orlando (Coll. Med. Evangelists 1947)

Leon, Andrew Joseph, Miami Beach (Middlesex 1946)

Luppold, Luther Samuel, White Haven, Pa. (Temple 1921)

McChesney, William Wallace, Gastonia, N. C. (Med. Coll. of Virginia 1915)

McCloskey, Bernard J., Jacksonville (Univ. of Pa. 1922)

McKenna, Thomas James, Ebensburg, Pa. (Univ. of Pittsburgh 1940)

Mahoney, Charles Leo, Terre Haute, Ind. (St. Louis Univ. 1932)

Manginelli, Vitus William, St. Petersburg (L. I. Coll. of Med. 1932)

Marr, Norval Mason, New York, N. Y. (Cornell 1948)

Massey, Bennie Jackson, Palatka (Med. Coll. State of S C. 1948)

Mehl, Omar Clayton, Ann Arbor, Mich. (U. of Pittsburgh 1936)

Meldrum, Thomas Wilson, Jacksonville (Cornell 1947)

Michael, Sidney Richard, St. Petersburg (Johns Hopkins 1941)

Miller, Claude Henry, Jr., Louisville, Ky. (Creighton 1945)

Miller, Marvin Black, Tampa (Univ. of Arkansas 1947)

Morgan, John Mettinger, Chamblee, Ga. (Emory 1945)

Morgen, Maximilian, Miami Beach (L. I. Coll. Hosp. 1921)

Neill, James Moreman, Gulfport (U. of Louisville 1943)

Nichols, Photis J., Miami (Emory 1948)

Nolan, Paul Vernon, Tampa (Univ. of Maryland 1948)

Northup, Edwin Charles, Avon Park (Bowman Gray 1946)

O'Neal, John Barnwell, III, Elberton, Ga. (Univ. of Georgia 1944)
O'Neal, Phyllis Johnson, Elberton, Ga. (Univ. of Georgia 1943)
Osterhout, Gail Merrill, McIntosh (Univ. of Georgia 1945)
Pace, Sherman Homer, Winston Salem, N. C. (Duke 1947)
Patient, William Fred, Mitchel Field, N. Y. (St. Louis Univ. 1933)
Piper, Robert Charles, Miami (Univ. of Wisconsin 1947)
Pitts, Robert Owen, Nashville, Tenn. (Vanderbilt 1943)
Pollen, William, Miami (N. Y. Med. Coll. 1948)
Polskin, Louis Julian, Birmingham, Ala. (Chicago Med. Sch. 1947)
Price, Walter Coachman, Pittsburgh, Pa. (U. of Pittsburgh 1947)
Pritchett, Joseph Henry, Jr., Augusta, Ga. (Univ. of Georgia 1948)
Pross, Philip, Passaic, N. J. (Cornell 1944)
Raider, Louis, New Orleans, La. (Dalhousie U. 1918)
Rask, Arthur Thomas, Cleveland, Ohio (Ohio State Univ. 1937)
Reeves, Geo. William, Washington, D. C. (Geo. Wash. Univ. 1943)
Reiss, Jack, Coral Gables (U. of Louisville 1932)
Rezek, Philipp Raphael, Miami (U. of Vienna 1921)
Rhea, Samuel Barclay Donaldson, Pensacola (Vanderbilt 1941)
Rhode, Geo. Milton, Jr., Jacksonville (Temple 1946)
Richmond, Henry John, Miami (St. Louis Univ. 1948)
Rodney, Marvin Benjamin, Brooklyn, N. Y. (Chicago Med. Sch. 1946)
Rosborough, William Daniel, Marianna (Univ. of Pa. 1931)
Rosenberg, Albert Aaron, Atlanta, Ga. (Univ. of Georgia 1943)
Rosenblum, Robt. Ronald, Whitestone, L. I., N. Y. (Middlesex 1946)
Runge, William Francis, Washington, D. C. (Georgetown 1944)
Sales, Louis Michael, Lake City (Boston Univ. 1935)
Salhanick, Louis, Fall River, Mass. (Middlesex 1944)
Sauberli, Harry Albert, Tallahassee (Vanderbilt 1932)
Schosheim, Arnold Mortimer, Glendale, L. I., N. Y. (Middlesex 1945)
Shapiro, David, Brooklyn, N. Y. (Middlesex 1945)
Short, Jean Lovett, Lakeland (Univ. of Pa. 1934)
Smith, Clyde Francis Brooke, Miami (Jefferson 1947)
Smith, Fred Augustus, McRae, Ga. (Emory 1941)
Smith, Vernon Lamaun, Miami (St. Louis Univ. 1948)
Sorvas, George Peter, Warren, Ohio (Hahnemann Univ. 1937)
Spivak, Abraham Henry, New York, N. Y. (Columbia U. Coll. of Phys. & Surg. 1931)
Stauffer, Floyd Randall, Warrington (Ohio State U. 1943)
Stauffer, Mary Ruth Schuh, Warrington (Ohio State U. 1943)
Stemerman, Irving, Newark, N. J. (Northwestern 1945)
Strain, Richard Edgar, Needham, Mass. (Vanderbilt 1935)
Terheyden, Wm. Anthony, Jr., Miami Beach (Jefferson 1947)
Tomlinson, Walter Benjamin, Pensacola (Northwestern 1946)
Trent, Sophie Clara, Jacksonville (Yale 1943)
Vaughan, James Anderson, Jr., West Point, N. Y. (U. of Maryland 1946)
Weeks, Joseph C., Lake City (Univ. of Tennessee 1932)
Weller, Walter, Gainesville (Cornell 1918)
Wilson, Leo Hughes, Hollywood (Duke 1947)
Winslow, James Addison, Jr., Cuthbert, Ga. (Emory 1944)
Witkind, Elliott, Brooklyn, N. Y. (Middlesex 1945)
Yarn, Charles Presh, Jr., Atlanta, Ga. (Emory 1945)
Zoeller, Allan Frey, Miami (Univ. of Louisville 1948)

NEW MEMBERS

The following doctors have joined the State Association through their respective county medical societies.

Bourkard, Ernest R., Tampa
Cunningham, Chas. B., St. Petersburg
Goddard, David W., Daytona Beach
Goodnow, Chester L., St. Petersburg
Graham, Henry H., Gainesville
Hotard, Roland F., Jr., Winter Park
Keedy, Christian, Miami
Lemberg, Louis, Miami Beach
McRae, James H., St. Petersburg
Meaney, Richard V., Punta Gorda
Needelman, Harry, Miami Beach
Northup, Edwin C., Avon Park
Reed, Howard W., Gainesville
Robinson, Julian, Miami
Smith, Frederico A., Miami
Smith, Mason C., Tampa
Steely, James A., Apalachicola
Stem, James M., Clearwater
Summerlin, Winston L., Gainesville
Ungaro, Ludwig M., North Miami

COMPONENT SOCIETY NOTES

Bay

On February 2, members of the Bay County Medical Society met with Dr. Roger F. Sondag, director of the Bureau of Preventable Diseases of the Florida State Board of Health, and Dr. Albert V. Hardy, director of the Bureau of Laboratories. The two speakers outlined the latest control and treatment procedures and the laboratory methods concerning cancer and syphilis.

The meeting was held at the Bay County Health Unit in conjunction with local health officers.

Brevard

The regular meeting of the Brevard County Medical Society was held on February 8 in Melbourne. The scientific session was devoted to movies on the diagnosis and treatment of pulmonary tuberculosis.

At the business meeting, the society voted to organize a woman's auxiliary to the society, and a tentative date was set for the organizational meeting.

At a special meeting of the society on February 21, held at the Indian River Hotel in Rockledge, Dr. Karl M. Houser of the University of Pennsylvania spoke on the issue of compulsory health insurance. Dr. Robert H. Ivy, professor of plastic surgery at the University of Pennsylvania, spoke on plastic surgery and demonstrated his address with lantern slides.

Guests other than the speakers included dentists of the county, Gen. Norman T. Kirk, retired surgeon general of the United States Army, Dr. J. J. Clark of Atlanta, Drs. Fred Mathers, Frank J. Pyle and Eugene L. Jewett of Orlando, Drs. Robert J. Jahn and Lee E. Parmley of Winter Haven, and Dr. Herbert Gibbey of Wilkes-Barre, Pa.

At this meeting the wives of the members were organized into a Woman's Auxiliary to the Brevard County Medical Society.

All members of the society have paid 1949 State Association dues.

DeSoto-Hardee-Highlands-Charlotte-Glades

Dr. S. L. Watson, Jr., of Lakeland was the guest speaker at the February meeting of the DeSoto-Hardee-Highlands-Charlotte-Glades County Medical Society, which was held at Aqua Vitae Springs. Dr. Watson discussed "Relative Infertility." Sixteen members and three guests attended the meeting.

Indian River

Members of the Indian River County Medical Society have paid their 1949 Association dues.

Marion

Members of the Marion County Medical Society held their regular monthly meeting on February 16 at the "1890 House." Dr. Eugene G. Peek, Sr., reported that the liaison committee to the health department had approved the proposed program submitted by Dr. Charles H. Blandford, director of the Marion County Health Unit, for the work to be done by the unit.

The following members were present at the meeting: Drs. William H. Anderson, Jr., Richard C. Cumming, T. Hartley Davis, Bertrand F. Drake, William H. Garvin, Jr., Henry L. Harrell, Eaton G. Lindner, Carl S. Lytle, William J. McGovern, Eugene G. Peek, Eugene G. Peek, Jr., Ralph E. Russell, Robert E. Thompson, Thos. H. Wallis, Harry F. Watt and Herbert M. Webb, Jr. Dr. Blandford was a guest.

Nassau

Association dues for 1949 have been received from all members of the Nassau County Medical Society.

Pasco-Hernando-Citrus

At the scientific session of the February 10 meeting of the Pasco-Hernando-Citrus County Medical Society, Dr. S. Carnes Harvard discussed "Postmenopausal Bleeding." A case of mucocele of the appendix and cecal area found incidentally after a hysterectomy was discussed by Dr. W. Wardlaw Jones.

In conjunction with the meeting, the annual "Ladies' Night" was held at the Magnolia Lodge in Crystal River. Members present were Drs. Donald G. Bradshaw, George R. Creekmore, S. Carnes Harvard, W. Wardlaw Jones, Jere W. Kirkpatrick, William B. Moon and William H. Walters, Jr. Guests of the society were Mrs. Bradshaw, Miss Daborah Coppleman, Mrs. Creekmore, Mrs. Harvard, Mrs. Jones, Mrs. Kirkpatrick and Mrs. Moon.

Polk

At the February meeting of the Polk County Medical Society, Dr. A. McGehee Harvey, professor of Clinical Medicine at Johns Hopkins University, was the guest speaker. Dr. Harvey presented an outstanding and enlightening paper on "The Disease Conditions of the Elderly Patient and Suggestions and Means of Adequately Caring for This Group of Patients."

Dr. Byron Y. Pennington, president, conducted the meeting. Eighty persons were present, including visiting doctors from Orlando and Tampa. Among the guests were Dr. Miller of Mountain Lake and Dr. Dohme of Sharp & Dohme.

Seminole

The entire membership of the Seminole County Medical Society has paid its State Association dues for 1949.

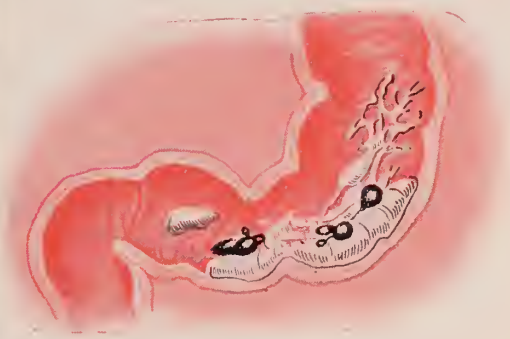
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— Hurst, A., in Portis, S. A.: Diseases of the Digestive System, ed. 2, Philadelphia, Lea & Febiger, 1944, p. 692.



MUCOUS COLITIS. In this x-ray is shown the distinctive string-like appearance of the descending portion of the lower bowel in mucous colitis, a condition frequently accompanying severe degrees of spastic or atonic colon. In the sagittal section is shown the over-secretion of mucus adhering to the bowel wall.



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Frank L. Keeler

Dr. Frank L. Keeler of Miami died at his residence on Dec. 7, 1948. He was 74 years of age.

Dr. Keeler received his medical education at the Lincoln Memorial University Medical Department, Knoxville, Tenn., which was later merged with the University of Tennessee College of Medicine. He was graduated in 1900. He began the practice of medicine in Indian Territory and had offices in Perry, Okla., before moving to Miami in 1918.

Early in 1945 Dr. Keeler retired from active practice because of ill health. Previous to that time, he had specialized in obstetrics. He was active in community affairs and through the years was especially known for his widespread work with the poor.

Dr. Keeler was an honorary member of the Dade County Medical Association and of the Florida Medical Association, and was also a member of the American Medical Association.

Survivors include two daughters, Mrs. Herbert Gaylord and Mrs. Helen Spach; a son, Emerson Keeler; five grandchildren and one great-grandchild, all of Miami.

James Emery Rawlings

Dr. James E. Rawlings of Daytona Beach died at Halifax Hospital on Dec. 23, 1948. He was 69 years of age.

Dr. Rawlings was born in 1879 in Raphine, Va. He was graduated from the University of Maryland School of Medicine and College of Physicians and Surgeons in 1904. A foremost local authority on skin diseases and malaria, he was forced to retire because of ill health three years before his death.

He served in the Spanish American War in 1898, first visiting Florida en route to Cuba. Shortly thereafter, he came to Daytona Beach. At the outbreak of World War I, Dr. Rawlings entered military service in England with the British Forces. When the United States entered the war, he transferred to the United States Army Medical Corps. He had an active interest in veterans' affairs, having served as commander of both

(Continued on page 658)

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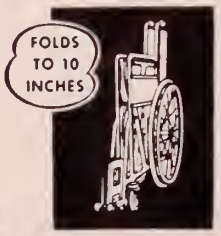
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the United Spanish War Veterans and the American Legion posts in Daytona Beach.

He was a member of the Volusia County Medical Society, a life member of the Florida Medical Association and a fellow of the American Medical Association.

Surviving are his widow, Mrs. Pauline Schon Rawlings, and a sister.

BOOKS RECEIVED

ANA PUBLIC RELATIONS WORKSHOP, A MANUAL OF PRACTICAL PUBLIC RELATIONS TECHNIQUES FOR THE GUIDANCE OF THE NATIONAL MEMBERSHIP OF THE AMERICAN NURSES' ASSOCIATION. By Edward L. Bernays. Price, $2.50. Pp. 32. Illustrations, 39. New York: American Nurses' Association, 1948.

This manual, prepared by the noted counsel on public relations, Edward L. Bernays, is such a comprehensive and useful work that it would be helpful to professional organizations of whatever field and should command wide general interest. It is a clear, simple, thorough, highly practical exposition of public relations technics, illustrated with 39 charts and photographs.

Prepared by experts for groups desiring to utilize the manifold technics of modern public relations on a day-to-day basis, this how-to book sets forth in direct, readable fashion how most effectively to utilize the press, radio and television, movies, direct mail, public meetings and other mediums of communication so as to give ideas and factual information the widest possible circulation among the public.

ANNUAL REPRINT OF THE REPORTS OF THE COUNCIL ON PHARMACY AND CHEMISTRY OF THE AMERICAN MEDICAL ASSOCIATION FOR 1947. Pp. 126. Chicago: American Medical Association, 1948.

The A.M.A. Council of Pharmacy and Chemistry Reports for 1947 are made available in a small volume for the convenience of physicians and others interested in medicine. The book contains reports of the Council previously published in the Journal of the American Medical Association, along with such editorial comments as have accompanied them, and also lesser reports included as a matter of record.

NEW AND NONOFFICIAL REMEDIES. Council on Pharmacy and Chemistry of the American Medical Association. Price $3.00. Pp. 800. Philadelphia: J. B. Lippincott Company, 1948.

This book is published annually under the direction and supervision of the Council on Pharmacy and Chemistry, a standing committee appointed by the Board of Trustees of the American Medical Association to consider medicinal and allied preparations offered by pharmaceutical and other manufacturers for prophylactic or therapeutic use by the physician. In this volume are listed and described articles which the Council has found acceptable up to June 15, 1948.

HEALTH EDUCATION. A publication of the Joint Committee on Health Problems in Education of the National Education Association and the American Medical Association. Price, $3.00. Pp. 413. Chicago: American Medical Association, 1948.

A completely rewritten 1948 edition of this standard textbook is now available. This comprehensive, readable and up-to-date volume contains the contributed material of nearly a hundred outstanding leaders in health education. Its clear, nontechnical presentation of material makes it excellent for supplementary reading as well as for a textbook.

Present day problems with solutions proved effective by experience are discussed in the twenty chapters under such titles as Health Problems: Past, Present and Future; Solving School and Community Health Problems; Finding and Using Resources, and Health Education in Action.

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Local Auxiliary Meets Leon-Gadsden-Liberty-Wakulla-Jefferson

The wives of the Chattahoochee doctors were hostess to the newly organized Woman's Auxiliary to the Leon-Gadsden-Liberty-Wakulla-Jefferson County Medical Society on January 20 at the Florida State Hospital in Chattahoochee.

Dr. John Seberg of the Florida State Hospital Dental Staff spoke on "Florine Treatment and Its Relation to Caries Prevention." Mrs. James B. O'Connor of Chattahoochee discussed the Constitution and By-Laws of the Woman's Auxiliary to the Florida Medical Association.

The auxiliary's officers for this year are: Mrs. Merritt R. Clements of Tallahassee, president; Mrs. Taylor W. Griffin of Quincy, vice president; Mrs. William D. Rogers of Chattahoochee, secretary; Mrs. Charles F. James, Jr., of Tallahassee, treasurer; Mrs. Ernest W. Ekermeyer of Tallahassee, membership chairman; Mrs. Benjamin A. Wil-

(*Continued on page 660*)

Advertisement



From where I sit *by* Joe Marsh

Get The Truth!

Called on my good friend "Cappy" Miller, who edits the County Bee, *just the other day. And hanging up on the wall of Cappy's office I noticed this slogan for his paper:*

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And from where I sit, once you've got both sides—and faced them truthfully, you realize that these differences of opinion are a precious part of what we call Democracy—the right of the individual to vote as he believes, to speak his mind, to choose his own beverage of moderation, whether beer or cider.

Joe Marsh

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kinson of Tallahassee, program chairman; Mrs. Bricey M. Rhodes of Tallahassee, publicity chairman; Mrs. Otis G. Kendrick, Jr., of Tallahassee, Hygeia distribution chairman. Dr. Charles F. James, Jr., of Tallahassee is medical advisory chairman.

After the meeting the ladies joined the doctors and their guests for dinner in the Staff dining room. Seventy-five were present.

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Surgery of Colon & Rectum, One Week, starting April 11, May 16, June 13.
Esophageal Surgery, One Week, starting June 13.
Thoracic Surgery, One Week, starting June 20.
Breast & Thyroid Surgery, One Week, starting June 27.
GYNECOLOGY—Intensive Course, Two Weeks, starting April 18, June 20.
Vaginal Approach to Pelvic Surgery, One Week, starting April 4, May 16, June 13.
OBSTETRICS—Intensive Course, Two Weeks, starting April 4, May 16.
MEDICINE—Intensive Course, Two Weeks, starting June 13.
Electrocardiography & Heart Disease, Two Weeks, starting July 18.
Gastroenterology, Two Weeks, starting June 27.
Personal Course in Gastroscopy, Two Weeks, starting May 16, June 13.
PEDIATRICS—Intensive Course, Two Weeks, starting April 4.
Diagnosis & Treatment of Congenital Malformations of Heart, Two Weeks, starting June 13.
DERMATOLOGY—Formal Course, Two Weeks, starting May 2.
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SCHEDULE OF MEETINGS

ORGANIZATION	PRESIDENT	SECRETARY	ANNUAL MEETING
Florida Medical Association	Joseph S. Stewart, Miami	Robert B. McIver, Jacksonville	Belleair, Apr. 10-13, 1949
Florida Medical Districts	Herman Watson, Lakeland	Council Chairman	
A-Northwest	Irby H. Black, Live Oak	William P. Hixon, Pensacola	Quincy, 1949
B-Northeast	Rabun H. Williams, Eustis	Charles C. Grace, St. Augustine	Palatka, 1949
C-Southwest	John M. Butcher, Sarasota	H. Quillian Jones, Ft. Myers	Sebring, 1949
D-Southeast	Russell B. Carson, Ft. Lauderdale	Erasmus B. Hardee, Vero Beach	Ft. Lauderdale, 1949
Florida Specialty Societies			
Derm. and Syph., Soc. of	A. Buist Litterer, Miami	Wesley W. Wilson, Tampa	Belleair, April 10, 1949
Genl. Practice of Med.	M. Crego Smith, Clearwater	Walter E. Murphree, Gainesville	Belleair, April 10, 1949
Health Officers' Society	Roger F. Sondag, Jacksonville	Lorenzo L. Parks, Jacksonville	Belleair, April 10, 1949
Industrial & Railway Surgeons	F. Hardy Bowen, Jacksonville	J. H. Mitchell, Jacksonville	Belleair, April 10, 1949
Neurology & Psychiatry	James G. Lyerly, Jacksonville	William H. McCullagh, Jacksonville	Belleair, April 10, 1949
Ob. and Gynec. Society	Chas. J. Collins, Orlando	Dorothy D. Brame, Orlando	Belleair, April 10, 1949
Ophthal. & Otol., Soc. of	Bascom H. Palmer, Miami	W. Jerome Knauer, Jacksonville	Belleair, April 10, 1949
Orthopedic Society	Charles B. Mabry, Jacksonville	Eugene L. Jewett, Orlando	Belleair, April 10, 1949
Pathological Society	James N. Patterson, Tampa	Gretchen V. Squires, Pensacola	Belleair, April 10, 1949
Pediatric Association, State	Edgar W. Stephens, W. P. Beach	Hugh A. Carithers, Jacksonville	Belleair, April 10, 1949
Proctologic Society	Dean W. Hart, St. Petersburg	Frederick E. Farrer, Miami	Belleair, April 10, 1949
Radiological Society	James F. Pitman, Lake City	Floyd K. Hurt, Jacksonville	Belleair, April 9-10, 1949
Urological Society	Milton M. Coplan, Miami	Russell B. Carson, Ft. Lauderdale	Belleair, April 10, 1949
Florida—			
Academy, Public Medicine	Robert T. Spicer, Miami	Shaler Richardson, Jacksonville	Belleair, April 13, 1949
Basic Science Exam. Board	Paul A. Vestal, Winter Park	M. W. Emmel, D.V.M., Gainesville	Gainesville, June 11, '49
Dental Society, State	T. C. Henslee, D.D.S., Miami	Larry Schulstad, D.D.S., Bradenton	
Hospital Association	Mr. H. Louie Wilson, Gainesville	Mr. H. A. Schroder, Jacksonville	November, 1949
Hospital Service Corporation	Mr. W. E. Arnold, Jacksonville	Mr. H. A. Schroder, Jacksonville	Jacksonville, Feb. 14, '50
Medical Examining Board	Homer L. Pearson, Jr., Miami	Frank D. Gray, Orlando	Jacksonville, June 26-28, 1949
Medical Postgraduate Course	Turner Z. Cason, Jacksonville	Chairman	
Medical Service Corporation	Leigh F. Robinson, Ft. Lauderdale	Herbert E. White, St. Augustine	Belleair, April, 1949
Nurses Association, State	Mrs. Elsie M. Airheart, Tampa	Miss Helen Shearston, Miami	Sarasota, October, '49
Pharmaceutical Association, State	Mr. D. M. Weaver, Miami	Mr. R. Q. Richards, Ft. Myers	Miami, May 17-19, '49
Public Health Association	Turner E. Cato, Miami	Mr. Fred B. Ragland, Jacksonville	West Palm Beach, Oct. 6-8, '49
Tuberculosis & Health Assn.	Judge Ernest E. Mason, Pensacola	Mr. Walton MacJordan, Orlando	Tampa, Apr. 21-22, '49
Woman's Auxiliary	Mrs. L. E. Parmley, Winter Haven	Mrs. C. R. Morgan, Jr., Miami	Belleair, Apr. 10-13, 1949
merican Medical Association	R. L. Sensenich, South Bend, Ind.	Geo. F. Lull, Chicago	Atlantic City, June 6-10, 1949
outhern Medical Association	Oscar B. Hunter, Washington, D. C.	C. P. Loranz, Birmingham	Cincinnati, Nov. 14-17, '49
labama Medical Association	J. Paul Jones, Camden, Ala.	Douglas L. Cannon, Montgomery	Montgomery, Ala., Apr. 19-21, 1949
eorgia, Medical Assn. of	Edgar Hill Greene, Atlanta	Edgar D. Shanks, Atlanta	Savannah, Ga., May 10-13, '49
E. Hospital Conference	Mr. Burton M. Battle, New Orleans	Mr. R. F. Whitaker, Atlanta	Biloxi, Miss., April 27-29, '49
outheastern Allergy Assn.	Oscar Swineford, Charlottesville, Va.	Kath. B. MacInnis, Columbia, S. C	Columbia, S. C., 1950
outheastern, Am. Urological Assn.	Harold P. McDonald, Atlanta	Russell B. Carson, Ft. Lauderdale	
outheastern Surgical Congress	Gilbert Douglas, Birmingham. Ala.	B. T. Beasley, Atlanta	Biloxi, Miss., May 23-26, '49

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	SOCIETY	PRESIDENT	SECRETARY	MEETING DATE	MEMBERS Total	MEMBERS Paid	COUNCILOR
A	Bay	Martle F. Parker, M.D. Panama City	Russell T. Stewart, M.D. 224 East 4th St. Panama City		15	7	
	Escambia *Santa Rosa	Alvyn W. White, M.D. 24 W. Chase St. Pensacola	Arthur J. Butt, Jr., M.D. 1101 N. Palafox St. Pensacola	2nd Tuesday 8:00 P.M.	61	8	
	Franklin-Gulf	Albert L. Ward, M.D. Port St. Joe	Donald H. Anderson, M.D. Port St. Joe	3rd Tuesday Odd Months	7	5	A-1-50 William P. Hixon, M.D. Pensacola
	Jackson *Calhoun	Daniel A. McKinnon, M.D. Marianna	Francis M. Watson, M.D. 120 Deering St. Marianna	3rd Thursday 7:30 P.M.	18	15	
	Walton-Okaloosa	Arthur G. Williams, Sr. Lakewood	Ralph B. Spires, M.D. DeFuniak Springs	3rd Thursday 8:00 P.M.	14	100%	
	Washington-Holmes	N. J. Dawkins, M.D. Vernon	B. W. Dalton, M.D. Chipley		5	100%	
B	Columbia *Baker-Hamilton	Robert B. Harkness, M.D. 525 E. Duval St. Lake City	Thomas H. Bates, M.D. 27 W. Madison St. Lake City	1st Monday 7:30 P.M.	16	100%	
	Leon-Gadsden-Liberty-Wakulla-Jefferson	Merritt R. Clements, M.D. 1232 N. Monroe Street Tallahassee	Edward C. Love, Jr., M.D. Masonic Temple Bldg. Quincy	Quarterly 7:30 P.M.	45	39	A-2-49 Irby H. Black, M.D. Live Oak
	Madison-Suwannee	A. Franklin Harrison, M.D. Madison	Irby H. Black, M.D. 918 W. Howard St. Live Oak		11	10	196
	Taylor *Dixie-Lafayette	Walter J. Baker, M.D. Foley	Ralph J. Greene, M.D. Perry	Last Friday 8:00 P.M.	4	3	
C	Alachua *Bradford, Gilchrist Union	Alva T. Cobb, Jr., M.D. 505 W. University Ave. Gainesville	F. Emory Bell, M.D. Box 400 Gainesville	2nd Tuesday 8:00 P.M.	37	33	
	Duval *Clay	Raymond R. Killinger, M.D. 225 W. Ashley St. Jacksonville	Janet G. Leser, M.D. 1016 LaSalle St. Jacksonville	1st Tuesday 8:15 P.M.	240	176	
	Marion *Levy	Robert E. Thompson, M.D. Holder Bldg. Ocala	Bertrand F. Drake, M.D. Professional Bldg. Ocala	3rd Wednesday 12:30 P.M.	28	25	B-3-50 Charles C. Grace, M.D. St. Augustine
	Nassau	David G. Humphreys, M.D. Fernandina	John W. McClane, M.D. Fernandina	Last Friday 8:00 P.M.	7	100%	
	Putnam	Grover C. Collins, M.D. 502 Reid St. Palatka	Lawrence G. Hebel, M.D. 119 N. 4th St. Palatka	2nd Tuesday 6:00 P.M.	9	100%	
	St. Johns	Reddin Britt, M.D. Box 565 St. Augustine	S. Raymond Cafaro, M.D. Exchange Bank Bldg. St. Augustine	3rd Tuesday 8:30 P.M.	15	14	
	Brevard	Charles E. Russell, M.D. 16 Magnolia St. Cocoa	Theodore J. Kaminski, M.D. Box 576 Melbourne	2nd Tuesday	14	100%	
	Lake *Sumter	Leroy H. Oetjen, M.D. Leesburg	William L. Musser, M.D. Mount Dora	1st Wednesday 7:30 P.M.	21	2	B-4-49 Rabun H. Williams, M.D. Eustis
	Orange *Osceola	Robert P. Henderson, M.D. 544 N. Orange Ave. Orlando	Gerald W. Jones, M.D. American Bldg. Orlando	3rd Wednesday 8:00 P.M.	136	109	
	Seminole	Leonard I. Munson, M.D. Touchton Bldg. Sanford	Frank L. Quillman, M.D. Box 158 Sanford	2nd Tuesday 5:30 P.M.	11	100%	
	Volusia *Flagler	Joseph H. Rutter, M.D. Rt. 1, Box 303-A Daytona Beach	Robert L. Miller, M.D. 258½ S. Beach St. Daytona Beach	2nd Tuesday 7:30 P.M.	53	46	573
D	Hillsborough	William M. Rowlett, M.D. Box 786 Tampa	Herschel G. Cole, M.D. 315 Wallace S. Bldg. Tampa	1st Tuesday 8:00 P.M.	150	84	
	Manatee	Willis W. Harris, M.D. First National Bank Bldg. Bradenton	Joseph A. Gibson, M.D. Palmetto	3rd Tuesday 7:00 P.M.	18	1	C-5-49 John M. Butcher, M.D. Sarasota
	Pasco-Hernando-Citrus	Donald G. Bradshaw, M.D. Zephyrhills	W. Wardlaw Jones, M.D. Box 247 Dade City	2nd Thursday 7:00 P.M.	12	10	
	Pinellas	Francis H. Langley 190 18th Ave. St. Petersburg	Whitman C. McConnell, M.D. 313 First Federal Bldg. St. Petersburg	1st Monday 6:30 P.M.	162	159	
	Sarasota	Millard B. White, M.D. 151 S. Pineapple Ave. Sarasota	Talmadge S. Thompson, M.D. Box 224 Venice	2nd Tuesday 8:30 P.M.	23	4	
	DeSoto-Hardee-Highlands-Charlotte-Glades	John A. Simmons, M.D. Box 430 Arcadia	Charles H. Kirkpatrick, M.D. Box 389 Arcadia	2nd Tuesday 8:00 P.M.	29	27	C-6-50 H. Quillian Jones, M.D. Ft. Myers
	Lee *Collier, Hendry	Curtis R. House, M.D. 2 Darling Bldg. Ft. Myers	Joseph L. Selden, Jr., M.D. 416 Richards Bldg. Ft. Myers	3rd Monday 7:30 P.M.	23	19	
	Polk	Byron Y. Pennington, M.D. Lake Wales	John W. Vaughn, M.D. Box 475 Lakeland	2nd Wednesday 7:00 P.M.	76	62	493
D	Indian River	John P. Gifford, M.D. Vero Beach	William L. Fitts, 3rd, M.D. Vero Beach Arcade Vero Beach	2nd Tuesday 8:00 P.M.	8	100%	
	Palm Beach	William E. Bippus, M.D. Comeau Bldg. West Palm Beach	Cecil M. Peek, M.D. 535 S. Flagler Dr. West Palm Beach	3rd Monday 8:00 P.M.	91	77	D-7-50 Erasmus B. Hardee, M.D. Vero Beach
	St. Lucie-Okeechobee-Martin	Adrian M. Sample, M.D. Box 897 Ft. Pierce	Jerome A. Megna, M.D. 706 S. 6th St. Ft. Pierce	3rd Thursday 8:00 P.M.	13	11	
	Broward	Paul G. Shell, M.D. 420 Sweet Bldg. Ft. Lauderdale	Scottie J. Wilson, M.D. 309 Blount Bldg. Ft. Lauderdale	4th Tuesday 8:00 P.M.	64	59	D-8-49 Russell B. Carson, M.D. Ft. Lauderdale
	Dade	John D. Milton, M.D. 1105 Huntington Bldg. Miami	Benjamin G. Oren, M.D. 628 duPont Bldg. Miami	1st Tuesday 8:30 P.M.	500	302	
	Monroe	James B. Parramore, M.D. 523 Whitehead St. Key West	Wallace H. Mitchell, M.D. 217 Duval St. Key West	2nd Thursday 8:00 P.M.	14	100%	690

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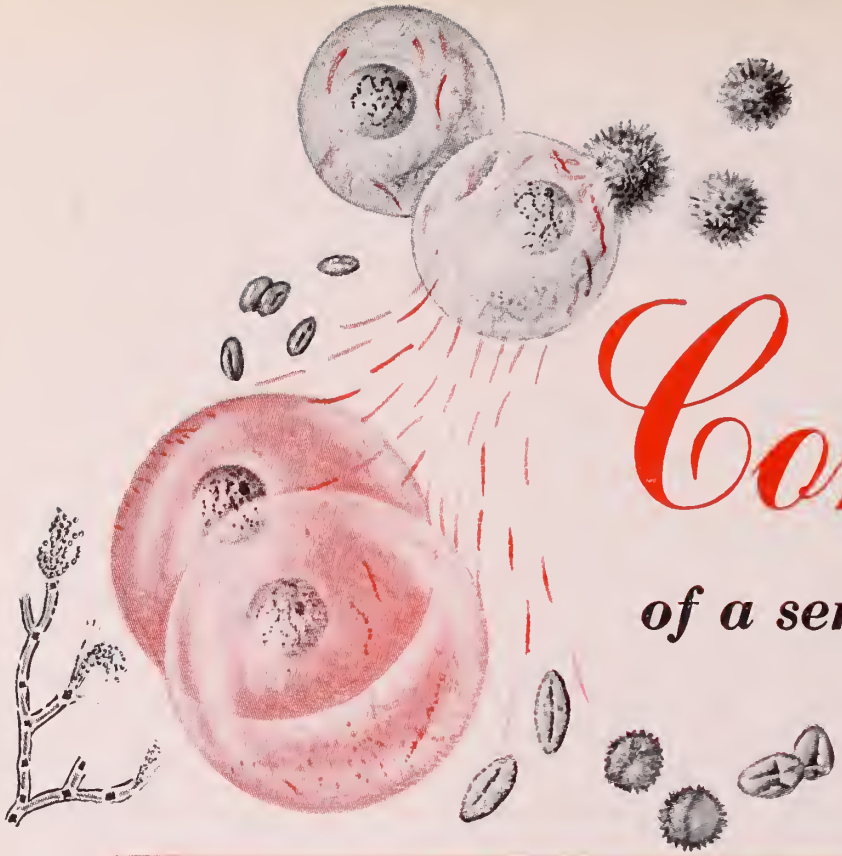
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A. R. Hollender

Ureteral Calculi in Children
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Volume XXXV MAY, 1949 No. 11

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Published monthly at Jacksonville, Florida. Price $5.00 a year; single numbers, 50 cents. Address Journal of the Florida Medical Association, P. O. Box 1018 (Fla. Theater Bldg.), Jacksonville 1, Fla. Telephone 6-1571. Accepted for mailing at special rate of postage provided for in Section 1103, Act of Congress of October 3, 1917: authorized October 16, 1918. Entered as second-class matter under Act of Congress of March 3, 1879, at the post office at Jacksonville, Florida, October 23, 1924.



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BIBLIOGRAPHY: 1. Brown, E. A.: Ann. Allergy 6:393, 1948. 2. Wittich, F. W.: Ann. Allergy 6:497, 1948.

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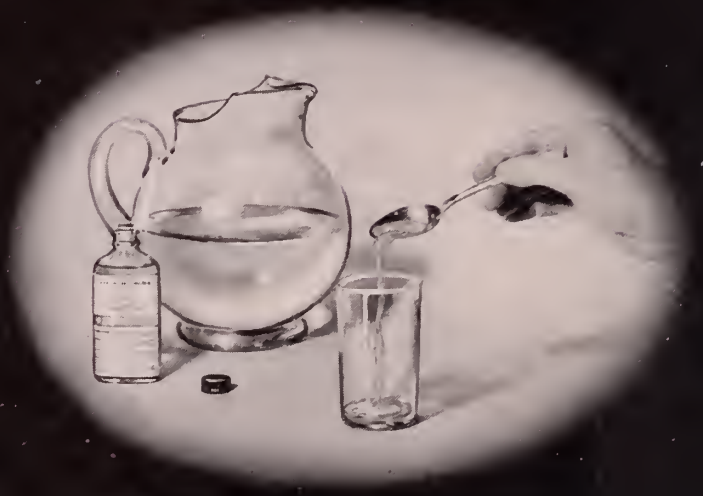
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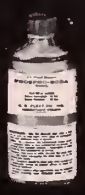
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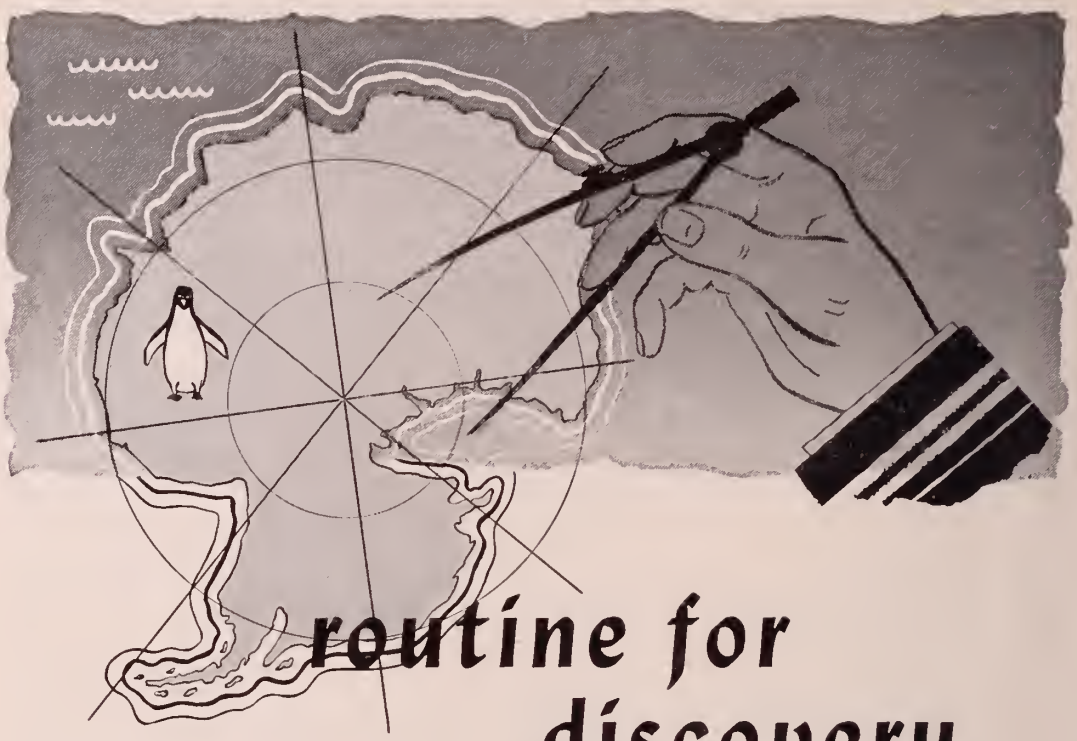
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(1) Joslin, E. P.: Postgraduate Med. 4:302 (Oct.) 1948. (2) Kemper, C. F.: Rocky Mountain M. J. 45:1092 (Dec.) 1948. (3) Pollack, H.: New York Med. 4:15 (Dec. 5) 1948

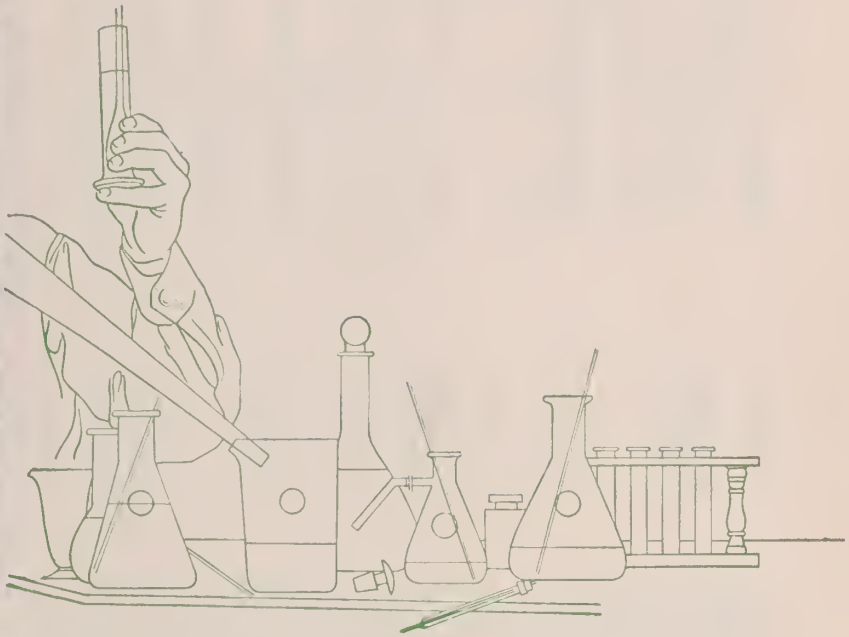
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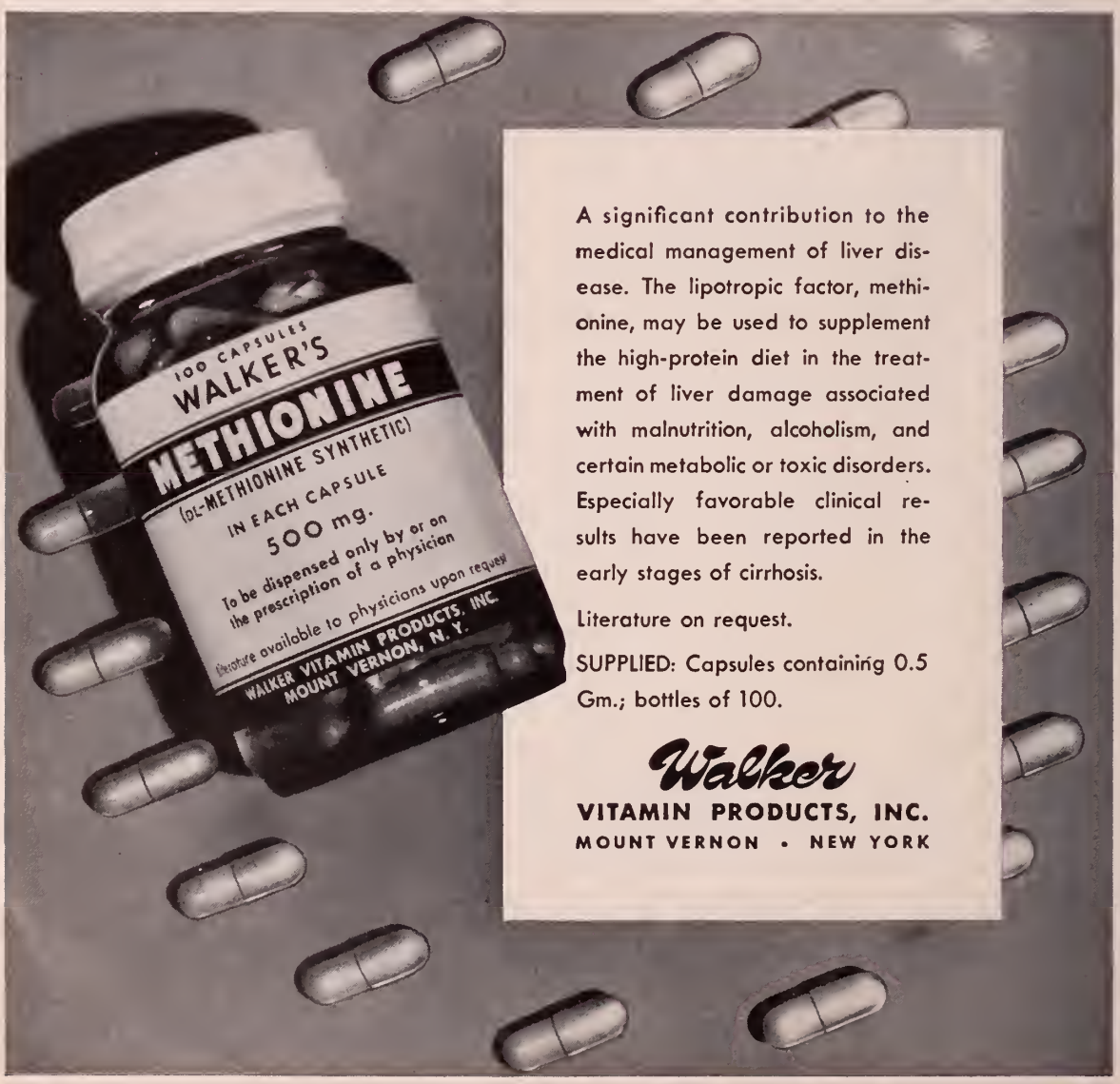
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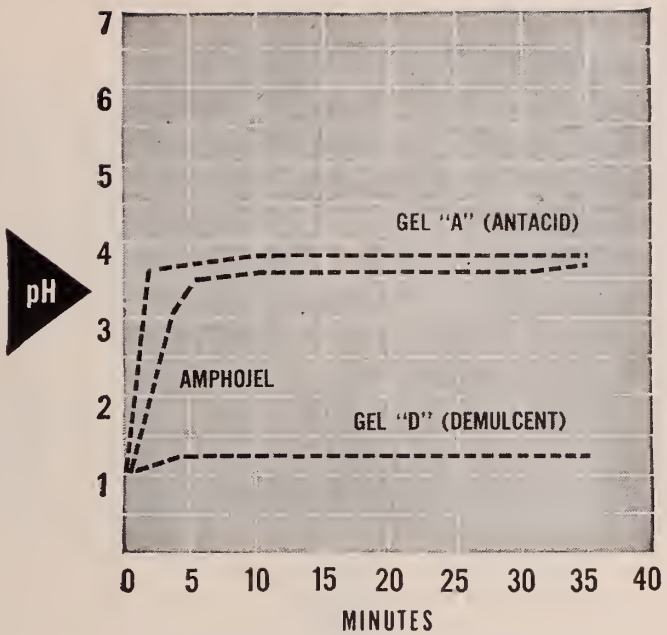


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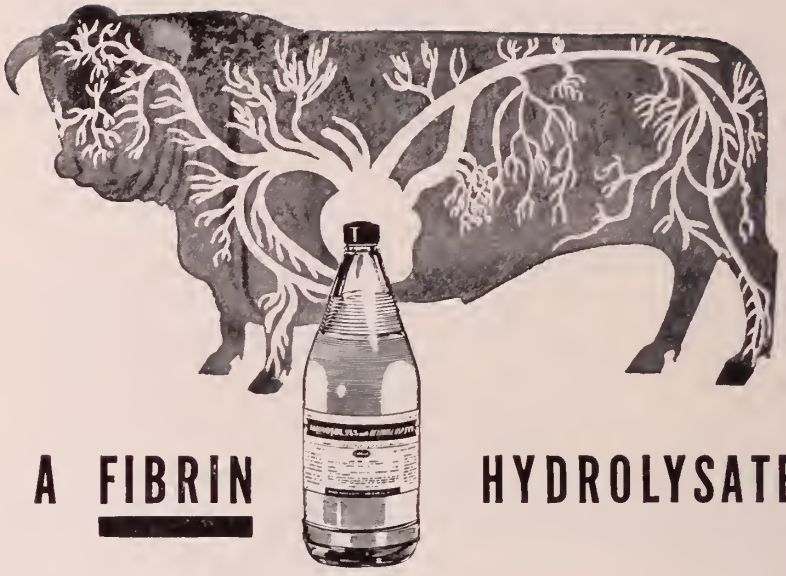
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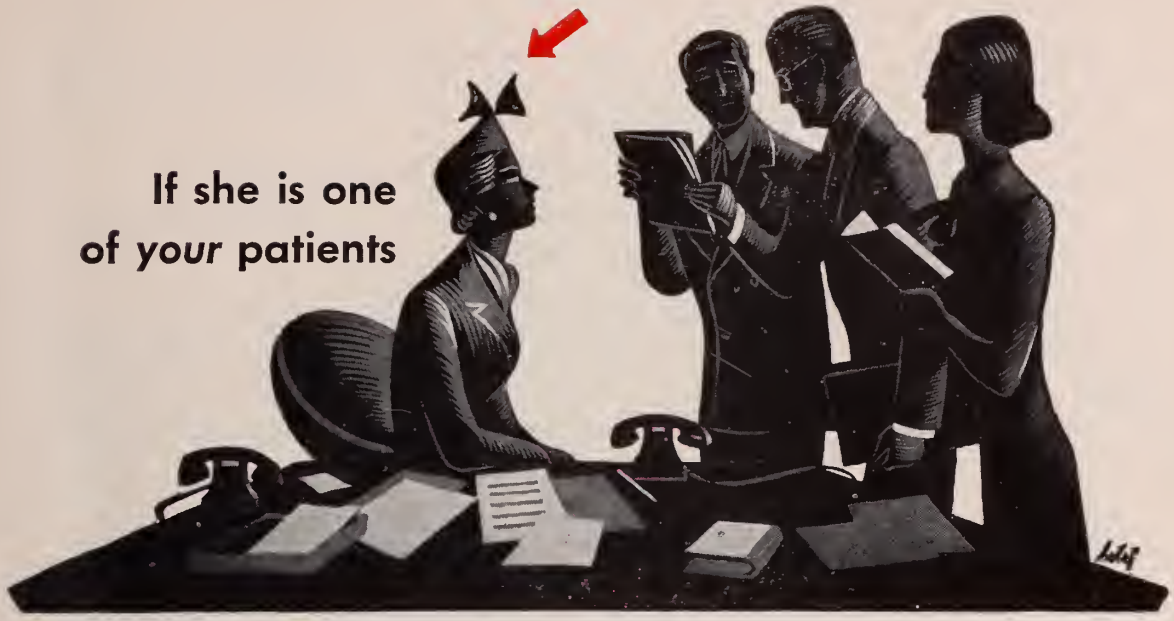
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1. Christensen, H. N., Lynch, E. L., Decker, D. G., and Powers, J. H. (1947), The Conjugated, Non-Protein, Amino Acids of Plasma. IV. A Difference in the Utilization of the Peptides of Hydralysates of Fibrin and Casein, J. Clin. Invest., 26:849, September.



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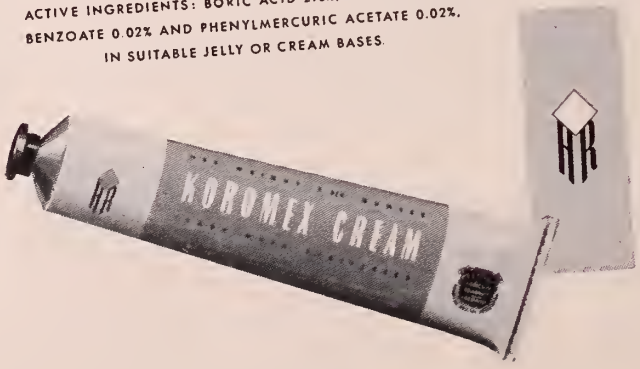


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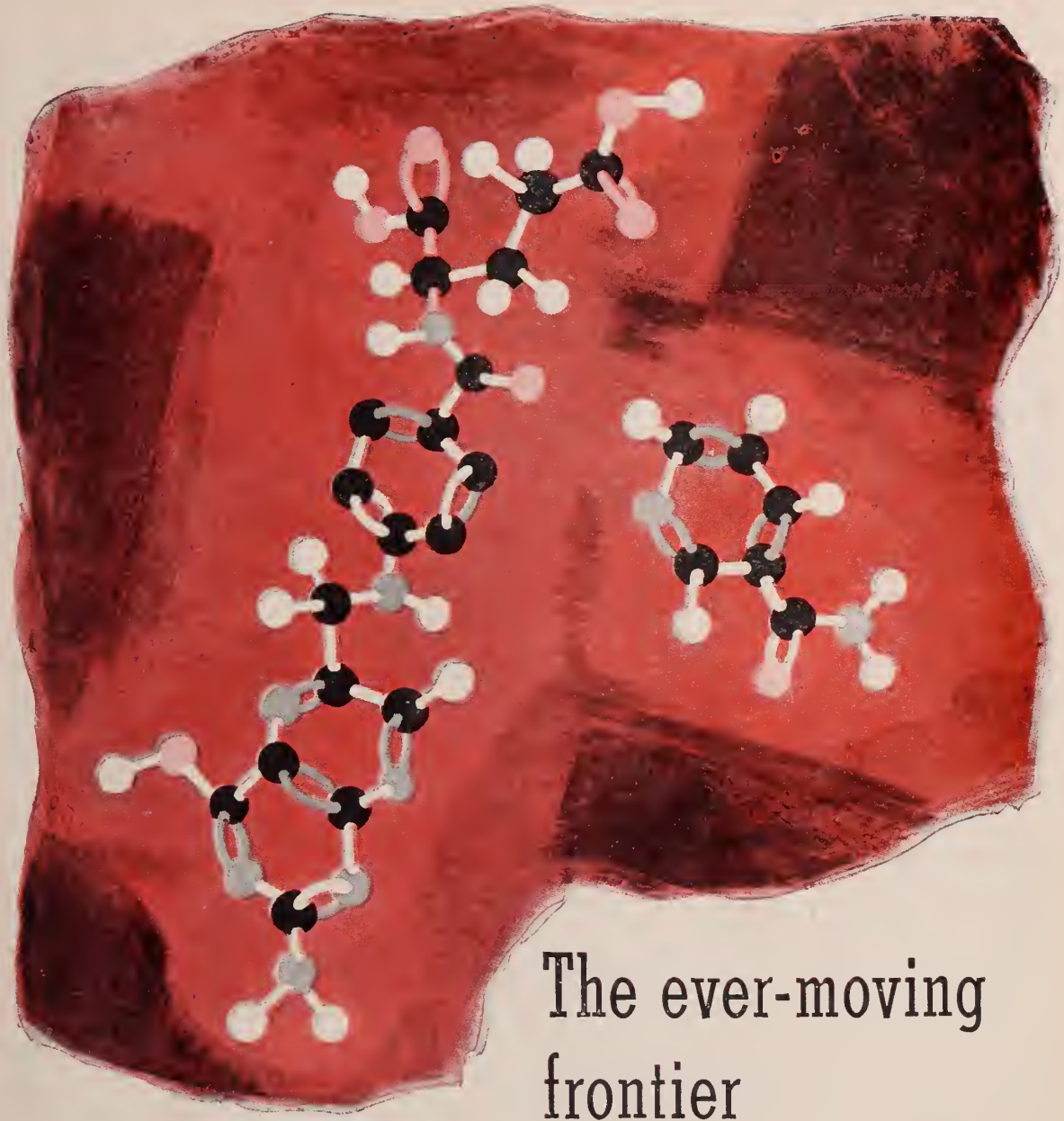
*Meyer, K. A., and Kozoll, D.D.: Progress in the Treatment of Carcinoma of the Stomach and Esophagus, South Dakota J. Med. & Pharm. 2:39 (Feb.) 1949.

The Seal of Acceptance denotes that the nutritional statements made in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.



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OCTOBER 17 — 22

We make this announcement so early in the year because many hundreds of physicians, surgeons, industrial physicians, health officers and other members of the profession have over the last ten years scheduled the event for May.

The change to October has been made in deference to requests from schools, colleges, adult education groups and community welfare organizations like the "Y's." They now look forward to wider and more effective participation because they can key the event into their health education and physical fitness programs early in the school term, thus avoiding vacation season interruptions.

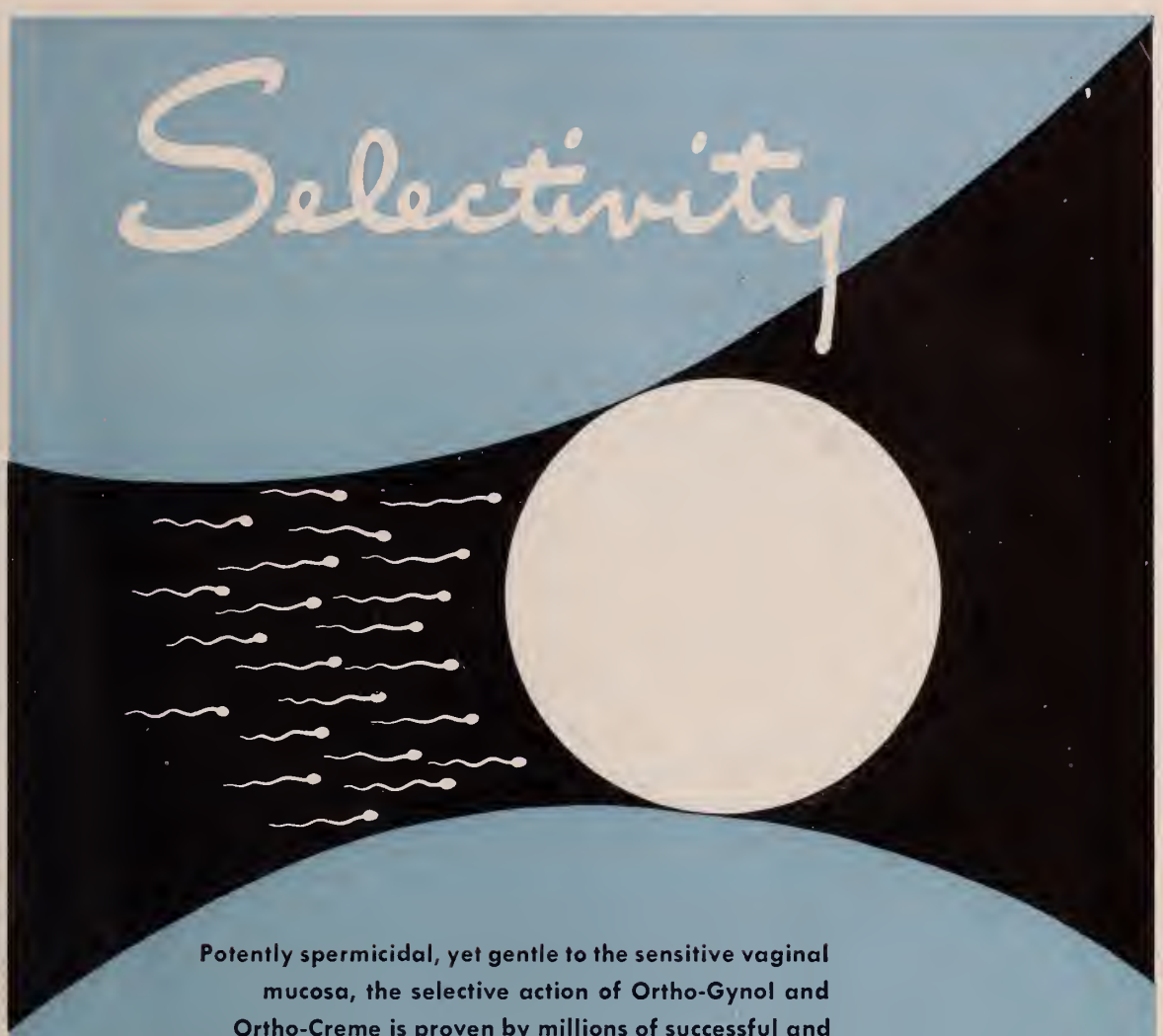
As National Posture Week enters upon its second decade, it is our privilege to thank the many, many physicians who have given it their approval as a worthy contribution to public health education. We pledge ourselves to carry on in the future as we have in the last ten years with National Posture Week and the daily work of The Samuel Higby Camp Institute for Better Posture. We shall do this to the limit of our resources in accordance with the ethical precepts of the profession.

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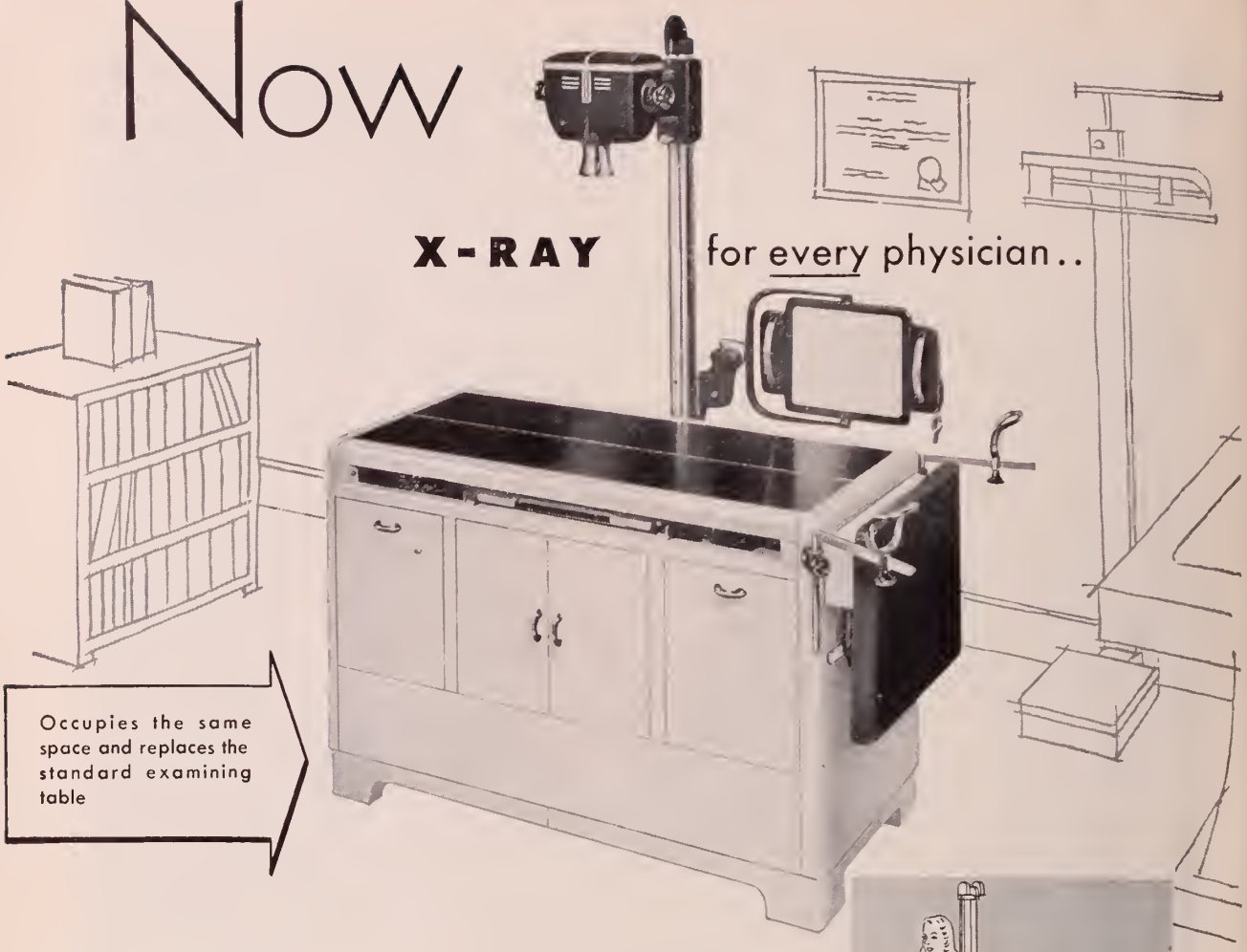
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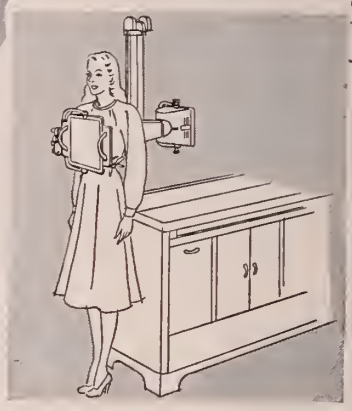
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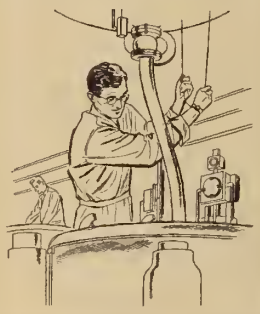
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THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION
PUBLISHED MONTHLY
Volume XXXV | Jacksonville, Florida, May, 1949 | No. 11

Nasal Sinusitis: Clarification of Certain Problems of General Interest

A. R. Hollender, M.D.
MIAMI BEACH

Several erroneous beliefs concerning nasal sinusitis have placed this disease in the category of uncertainty not only with the laity but more especially with the general practitioner. There is no justifiable reason why a patient should remark: "I have sinus trouble. I know I can't be cured, but maybe you can give me some relief." Nor is there justification for the general practitioner's advice to his patient: "Don't permit any specialist to operate on your nose or sinuses." Obviously, statements like these are made either through ignorance of or through prejudice toward the problem of sinusitis as it is understood today.

Because a certain friend has had some intranasal surgery done without a completely successful result, because Mr. X has had multiple operations for the removal of polyps, because Mrs. R. still does not breathe through her nose despite the fact that she has had a septal resection performed—all these reasons are unfavorable situations which cause dissatisfaction, but in themselves they are insufficient to nullify accepted indicated therapeutic methods and procedures.

The fact remains that physicians often pass judgment without knowing the circumstances involved in a certain case. For example, a patient who has had a chronic hyperplastic sinusitis for several years without permitting the rhinologist to do more than extirpate a few polyps from the nose itself has no right to condemn sinus surgery; he has never had the opportunity to judge whether he would have benefited from more radical procedure on the sinuses themselves. The patient who has had chronic ethmoiditis with pronounced postnasal dripping, frontal and occipital headache and definite systemic symptoms has little cause to criticize any form of modern accepted sinus therapy as long as he insists on resorting to irrational therapy. The patient who becomes an addict to nose drops, with the hope that such medication in itself will cure his sinusitis, and who ultimately is disappointed, has a case against the physician who unwisely prescribed such inadequate therapy and not against the modern scientific management of sinus disease.

Occasional failures in end results of nasal sinus treatment are common and acknowledged, but as stated before, the circumstances under which each patient is treated have a definite influence on the outcome. Patients in whom the pathologic process in the sinuses progresses unfavorably either have not been in expert hands or have refused other than temporizing procedures.

This is not the time to argue for or against conservative or radical therapy of nasal sinusitis. Suffice to say, there are definite indications for both, and one should not, therefore, permit a dogmatic viewpoint to develop. When the indications for radical surgical intervention are clear-cut, nothing short of such intervention will bring about a satisfactory result. Unfortunately, however, even some rhinologists have held to narrow views on the subject and have persisted in carrying out office procedures for indefinite periods when they well know at the outset that only more drastic aid can bring about a satisfactory conclusion.

The rhinologist who now neglects to take cognizance of the role played by allergy in the causation of nasal and sinus disease is destined to obtain poor results despite the utilization of every other form of rhinologic management. The patient who has had a septal resection and still cannot breathe after complete healing has taken place is probably a candidate for the allergist. While no accurate percentage is ventured, it is safe to say that the larger portion of the group of patients suffering from sinusitis have at the same time some allergic involvement. Treatment of the sinusitis alone, or the allergy alone, is usually ineffective, but when there is evidence of an allergic factor, allergic management becomes just as im-

Read before the Staff of St. Francis Hospital, Miami Beach, Aug. 30, 1948.

perative as rhinologic treatment, if a successful result is to be anticipated.

This presentation has not for its purpose the inclusion of technical details. These belong exclusively in the realm of the rhinologist. There are, however, certain considerations which merit general discussion, and which, after the introductory remarks already made, should be of interest to every physician. To bring these considerations before you, I have propounded several pertinent questions. In the answers to these questions it will be obvious why the problem of nasal sinusitis is of general interest.

The questions, and the order in which they will be discussed, are as follows:

1. How does nasal sinusitis develop?
2. How does the disease manifest itself?
3. Is sinusitis capable of acting as a focus of infection?
4. What is the relationship of allergy to nasal sinus disease?
5. What is the status of nasal medication?
6. What complications may result from nasal sinusitis?
7. What modern methods are employed in the diagnosis of sinusitis?
8. Is nasal sinusitis a curable disease?

1. How Does Sinusitis Develop?

Sinusitis usually follows an acute head cold, or as it is often called, an acute rhinitis. The factors which predispose to disease of a sinus cavity may well be classified as local and general. Of the local factors, anatomic irregularities of the septum, devitalization of the nasal mucosa from trauma or systemic disease, and allergy are the more important. Of the general factors, overexposure to cold, swimming, a lowered resistance, and poor general health are of major consideration. When one or more of the local and general factors are present, sinusitis may develop. In a sense, sinusitis is a complication of the common cold which has run its course but which has not cured spontaneously.

It should be remembered that the nasal mucosa always harbors bacteria. Under ordinary circumstances these bacteria are harmless. Once the resistance of the body is lowered, however, the bacteria become active because the body defenses are unable to retard their invasion into the deeper structures. The sinus cavities, which are lined with mucous membrane, are promptly subjected to infection by contiguity. At first the disease resembles that of an acute cold, but as the infection progresses, systemic as well as local symptoms develop, rendering the diagnosis of sinusitis no difficult task.

2. How Does the Disease Manifest Itself?

Sinusitis may manifest itself by one or several symptoms, but occasionally these symptoms are not obvious and a so-called latent or silent sinusitis may be present. When there is a history of the common head cold, and there is profuse discharge, and nasal breathing is difficult or impossible because of the congestion of the nasal membranes, sinusitis should be suspected. Headache when present is localized over the particular sinus or sinuses involved. In acute sinusitis, in addition to the local symptoms, chills and fever are not of infrequent occurrence. The patient may not be aware of the existence of a sinus infection until the diagnosis is made by the rhinologist, but in many instances the symptoms are so definite and the patient so familiar with those characteristic of the disease that he is able to generalize on the diagnosis himself. This is why patients when asked for their complaint promptly answer, "sinus trouble."

In chronic sinusitis, headache on awakening in the morning is more or less typical. When to this is added postnasal discharge, intermittent nasal blockage, probably some ocular discomfort and general fatigue, a diagnosis of chronic sinusitis has to be seriously entertained. Which of the sinuses is involved can usually be determined with the aid of modern diagnostic methods.

3. Is Sinusitis Capable of Acting as a Focus of Infection?

There are different opinions concerning the likelihood of sinusitis acting as a focal source of infection. In some quarters the view is held that a sinus infection does not differ from a tonsillar infection. In other centers, the opinion expressed has been otherwise, and little credence is given to the theory that, for example, a maxillary sinusitis can be the focus of infection in a generalized arthritis.

According to one authority, the part played by the sinuses as a focus of infection is less important than that of the tonsils, and the symptoms are less severe. This author stated further: "With the exception of the ethmoid the accessory sinuses seldom act as an important focus of infection, and the more chronic the infection and the more

evident the purulent discharge, the less likelihood of their being a source of general toxemia."

Despite this statement, when cultures from a sinus show pathogenic bacteria, and when other focal sources can be excluded in the presence of systemic disease, serious consideration must be given to such a sinus as a focus of infection. One authority ranks the sinuses third as a focus of infection, being preceded in importance by the teeth and tonsils. He believes that sinusitis should be regarded as a contributing factor rather than the direct cause of generalized infection.

4. What Is the Relationship of Allergy to Nasal Sinus Disease?

As has been stated in the introductory remarks, there is a definite relationship of allergy to nasal sinusitis. This is now common knowledge and must be fully appreciated if the management of sinusitis is to be rational. Unless one applies the present broad knowledge of allergy to nasal sinus disease, the results of the therapeutic methods commonly employed will be disappointing. In only 30 to 40 per cent of all sinus cases can the cause be said to be infection only.

Nasal and sinus allergy is a reversible state if the offenders are removed before hyperplasia of the membranes takes place. Once the latter process occurs, a superimposed infection is the usual course. The process is then one of allergy combined with infection. This combined state eventually progresses and leads to irreversible (polypoid) changes of the nasal and sinus membranes.

When a hyperplastic state of the nasal and sinus membranes occurs, patients exhibit symptoms which simulate those of the common cold. Chilling of the body exaggerates the symptoms and eventually leads to bacterial changes which result first in a watery, then in a purulent discharge.

In chronic asthma of the allergic type, the nasal sinuses are frequently involved. In fact, some authors have reported that 90 per cent of asthmatic patients present some form of nasal or sinus involvement.

5. What Is the Status of Nasal Medication?

The belief that "nose drops" are of curative value in sinusitis is fallacious. In the very early stage of an acute infection of the upper part of the respiratory tract, nose drops should not be employed as their utilization only tends to prolong the nasal blockage incident to the condition. There may be some justification for the use of nasal medication in the subacute stage of nasal sinusitis, but then only for a brief period. As soon as the symptoms abate, such local therapy should be discontinued.

Most of the nasal medicaments used today are astringent in action, some more so than others. Markedly astringent preparations are definitely harmful, producing violent headaches, overstimulation of the well-being, and worse than these symptoms, a severe secondary reaction during which the nasal blockage becomes more pronounced than at first. If it is imperative, as it is in some instances, to provide aeration and drainage, the use of mild astringents is justifiable, but, as has been stated previously, only for a brief period. The persistent and continuous use of any form of nasal medication leads to mucosal injury, and sometimes even to complete destruction of the nasal cilia with consequent disturbance of nasal physiology.

The current trend of pharmaceutic houses to combine one of the sulfa drugs or penicillin with a nasal astringent may have some theoretic basis. From a practical point of view, however, since these preparations have not been found to possess any greater virtues than astringents alone, their use in nasal sinusitis is without any scientific basis. Furthermore, sensitivity to the topical administration of the sulfonamides is common, and in patients with nasal allergy, the symptoms are usually aggravated.

If astringent nose drops are to be used at all, they must be administered correctly. Experience has demonstrated that maximum effects are obtainable only by the postural methods of Proetz or Parkinson. The so-called Proetz displacement method has produced good results in indicated cases, especially in adults, while the Parkinson treatment has served its more useful purpose in infants and children.

Finally, it should be remembered that present day teaching is opposed to the use of antiseptic preparations in the nose. The principles of good rhinologic therapy are based on the provision of ventilation and drainage. Since the astringents in themselves provide this action, the addition of antiseptics serves no useful purpose.

6. What Complications May Result from Nasal Sinusitis?

Because of the anatomic relationship of the nasal sinuses to other structures, the potentiality

of complications must always be considered. The complications may be of a mild character and easily controlled, or they may be severe. Osteomyelitis of the cranial bones belongs to the latter category. Occasionally, one encounters also meningitis and brain abscess, and in extreme situations, cavernous sinus phlebitis or cavernous sinus thrombosis. Frontal sinusitis and ethmoiditis seem to cause intracranial complications more commonly than disease in the other accessory nasal sinuses. Maxillary sinusitis only rarely produces intracranial complications. In general, acute sinusitis is more likely to progress and involve the intracranial structures than chronic sinusitis. There are, of course, definite pathways by which infection progresses and develops.

There seems to be some controversy concerning the relationship of sinusitis to certain pulmonary conditions, more particularly bronchiectasis. The more general belief now is that infection extends from the sinuses to the lower part of the respiratory tract rather than in the reverse direction. There are definite causes for this belief, chief among which is the fact that when the focal source in the sinuses is eliminated, improvement takes place in the chest process. When to this is added the fact that sinus infection is found in practically three fourths of all cases of bronchiectasis, the significance of the sinuses as a likely focal source at once becomes apparent.

Another complication of nasal sinusitis is otitis media. Occasionally the sinusitis may be of the latent or silent type. In most instances, the sinusitis is on the same side as the middle ear condition. When the sinusitis is controlled, the ear involvement usually subsides. There are some cases on record, however, in which the aural complications became severe, eventuating in mastoiditis. The possibility of middle ear complications resulting from sinusitis must always be borne in mind.

Orbital and ocular complications should be included in this discussion. It is plausible to assume that sinusitis may extend to the orbital cavity producing cellulitis and even abscess formation. It is likewise reasonable to assume that impairment of ocular function may be produced by severe sinus infection.

In all cases of ocular difficulties of undetermined origin, an investigation of the nasal sinuses is in order and should be performed. Occasionally, the relationship is verified when treatment of the sinusitis improves the ocular trouble.

7. What Modern Methods Are Employed in the Diagnosis of Nasal Sinusitis?

The history is important. As already stated, the common head cold generally precedes the onset of an acute sinusitis. By intranasal examination one finds evidence of more than nasal trouble. The membranes are congested and swollen, producing blockage to nasal breathing. A discharge is present in some part of the nose, depending on which of the sinuses is involved.

After the intranasal structures are inspected, transillumination is employed as a routine procedure. It serves as a guide in diagnosing involvement of the anterior sinuses, but is of no value in passing judgment on the posterior sinuses. For these, the roentgenogram is more often necessary to form a conclusive opinion. And if doubt still remains, irrigation of the suspected sinus cavity, or filling of the sinuses with lipiodol, must be employed.

Interpretation of the roentgenogram is not always a simple matter. One must consider the duration of the disease, the possible existence of allergy, and other factors which may produce misleading shadows.

A combination of diagnostic methods is often necessary to arrive at a diagnosis. In all cases, however, correlation of the findings with the clinical picture is important before a final opinion is ventured.

8. Is Nasal Sinusitis a Curable Disease?

The erroneous belief that nasal sinusitis is incurable should be corrected. True, some patients with markedly advanced hyperplastic disease never obtain a so-called pathologic cure. It is the exception rather than the rule, however, for such patients not to be symptomatically cured, if they will submit to modern methods of management.

Nasal sinusitis is a curable disease provided a correct diagnosis is made and adequate treatment is instituted before irreversible mucosal changes take place. The rationale for the therapeutic procedure or procedures employed should be well established. Resort should not be had to radical methods if more conservative ones will suffice. If there is doubt as to which should be used, and if there is no hazard in doing so, conservative treatment warrants a thorough trial.

It should be remembered that many patients with acute sinusitis get well spontaneously. In only a comparatively small percentage does the

chronic disease develop. In this group a considerable number would be cured if early rational therapy were instituted. Unfortunately, as with tuberculosis and cancer, the diagnosis is not made early enough to make possible a favorable result with conservative therapy. After the pathologic process has advanced, surgical rather than nonsurgical measures may be indicated. This does not imply radical treatment, because many surgical measures belong in the category of conservative therapy.

Therapeutic methods in rhinology have undergone vast changes during the last three decades. The changes have been occasioned by a better understanding of the physiology of the nose and its accessory sinuses. Advances in allergy and histopathology of the upper part of the respiratory tract have likewise revolutionized rhinologic therapy.

There is sufficient histopathologic evidence to demonstrate that sinus membranes possess reparative properties. They usually correct themselves if and when favorable conditions are established for the sinus cavity, namely, ventilation and drainage through a well functioning sinus ostium.

Both the physician and the layman are responsible for the confusion now existing concerning the prognosis of nasal sinusitis. Sinusitis is curable in the large majority of persons afflicted with this disease. The prognosis is reasonably good when, as stated previously, the diagnosis is made early and the correct therapeutic measures instituted.

Summary and Conclusions

Occasional failures in end results of nasal sinus treatment are common and acknowledged, but the circumstances under which each patient is treated have a definite influence on the outcome.

Sinusitis follows a more or less definite pattern in its development, usually beginning with a head cold, but certain general factors like a lowered resistance and inadequate body defenses help to intensify the infection of the mucous membranes of the entire respiratory tract.

Acute sinusitis should be suspected when there is a history of the common head cold, profuse discharge and impaired nasal breathing. In chronic sinusitis the characteristic symptoms are headache on arising, intermittent nasal blockage, postnasal discharge, ocular discomfort and general fatigue.

A nasal sinus may act as a focus of infection when cultures show pathogenic bacteria, and when other focal sources can be excluded.

An allergic state of the nasal sinus membranes is reversible if the offenders are removed before hyperplasia of the membrane takes place. When the allergy is combined with infection, progressive changes occur, eventually leading to a polypoid or irreversible state.

The mere instillation of "nose drops" will not cure nasal sinusitis. The habitual use of nasal medication leads to mucosal injury, destruction of the cilia and consequent impaired nasal function.

Sinusitis is capable of producing mainly aural, ocular, pulmonary or intracranial complications.

When a conclusive diagnosis cannot be made clinically, resort should be had to the roentgenogram with or without the use of radiopaque substances.

Nasal sinusitis is a curable disease provided the correct diagnosis is made and adequate treatment instituted, as indicated, before irreversible changes in the lining membrane of the sinus cavity take place.

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On Data of Notable Interest

Ureteral Calculi in Children

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PENSACOLA

Urinary calculi in children are seldom encountered in the Western Hemisphere, and ureteral stones are distinctly rare.[1-6] In a collected series of 2,096 cases of ureteral calculi, there were 16 cases in the young, an instance of 0.8 per cent.[6]

The symptomatology of a stone impacted in the ureter, especially in a child, may be confused with numerous medical and surgical conditions. A stone migrating down the ureter often presents a picture of the so-called "acute surgical abdomen." Despite their rarity in children, ureteral calculi must be considered in the differential diagnoses when the cause of pain, pyuria, hematuria, or obstructive uropathy is being sought.

Etiology and Pathology

Most ureteral stones in the very young are composed of uric acid. In older children, when the urine is sterile, the stone is usually composed of calcium oxalate. When infection exists, the stone is almost always phosphatic. Occasionally cysteine stones are encountered, in which case cysteinuria is present.[1b,7] Urinary stones in children are generally round or oval, smooth, and small. They are usually not greater than 5 mm. in diameter, although a few cases of giant ureteral calculi in children have been reported.[8-10] Boys are affected about twice as frequently as girls. Ureteral stones occur equally on the two sides. Bilateral calculi are found in 2 to 3 per cent of cases.

The great majority of ureteral stones originate in the kidneys. Primary stones in infants may be due to gastrointestinal disturbances, deficient alimentation, faulty elimination, or hereditary factors.[6] Urinary stasis and infection must be considered together in the formation of secondary calculi. Rarely, a calculus may form in a congenital diverticulum of the ureter. Over 90 per cent of the stones engaged in the ureter will pass spontaneously into the bladder. Ureteral obstruction due to congenital stricture, diverticula, adhesions, inflammatory or tumor masses, or anomalous vessels is almost invariably present when the stone fails to reach the bladder. When a stone is present, it interferes with ureteral peristalsis. Also, inflammatory stricture will often result at the site of obstruction. Complete ureteral obstruction due to stones rarely develops in children as a child's ureter dilates more readily than an adult's. Too, the stone usually becomes flattened, grooved, or canalized, thus allowing drainage around it. Nevertheless, some degree of urinary back pressure usually accompanies any ureteral stone.

Symptoms

When a stone passes from the kidney into the ureter and down into the bladder, there is almost invariably pain, but a child suffers far less than an adult would under similar circumstances. The clinical picture of ureteral stone in older children is usually similar to that seen in adults; however, in infants the definite symptomatology may be confusing.[11] In all ages of childhood, the failure to consider calculous disease commonly causes a stone to be entirely overlooked. Undoubtedly, some attacks of colic in infants and children are urologic rather than intestinal and result from passage of "gravel" or clusters of crystals. Children suffering from urinary calculi are usually subjected to intra-abdominal exploratory surgery or are treated for months and years for so-called pyelitis before the true cause of their symptoms is discovered. Also, many children with recurrent hematuria are treated for glomerulonephritis. Finally, because of persistent pyuria or hematuria, a urologic examination is performed, and the stone may be discovered—often, too late. If calculous disease were considered more often in the young, prompt investigation and proper treatment would alleviate much suffering, save many kidneys from ultimate injury and sacrifice, and in some instances save life.

Ureteral colic usually begins in the costovertebral angle or in the right upper quadrant and is sharp, stabbing, cutting, or tearing in character. Generally, the onset is sudden, and in children is often ushered in with chills and sometimes convulsions. The attack may last a few minutes to several hours. After the attack subsides, "gravel" or true calculi may be found in the urine. Pain referred through the celiac ganglion often causes nausea, vomiting, and sometimes constipation. Macroscopic hematuria commonly accompanies ureteral colic, but bleeding may be microscopic, as

Read before the Escambia County Medical Society, Pensacola, June 8, 1948.

is the usual case during intervals between attacks.[12] Disturbances of urination may be a reflex manifestation. When urinary infection is present, however, frequency, urgency, pain, and hematuria may be due entirely to inflammation. Ureteral colic may simulate intestinal colic, intestinal obstruction, appendicitis, or numerous other acute diseases of the abdomen. Enteric pain is intermittent and is usually associated with constipation or diarrhea; urinary disturbances are absent. With stone colic, the child cries throughout the attack, the bowel movements are usually normal, and urinary disturbances are common. Often there is great reflex abdominal distention; however, the abdomen is usually soft, the pain is more pronounced in the flank, and fever is absent, unless infection exists. Urinary disturbances are present, and blood is found in the urine. It should be remembered that hematuria may occur in appendicitis as a result of ureteritis produced by the overlying inflamed appendix.

Diagnosis

A complete physical examination is the first prerequisite for the diagnosis of ureteral stone. Palpation of the renal areas may reveal one or both kidneys to be tender, and the kidney on the involved side may be enlarged. When deep palpation is permissible, tenderness may be elicited along the course of the ureter. Microscopic hematuria is present in the majority of cases, and the urine is usually infected. The causative organisms may be determined by smears of the urinary sediment which are stained with methylene blue or Gram's stain and examined under oil immersion lens. Urine culture must be done when more detailed identification of the organisms is desired.

The importance of determining renal function in these cases cannot be overemphasized. If the child is old enough to cooperate, a test for phenolsulfonphthalein elimination may be performed. Blood urea nitrogen, nonprotein nitrogen, creatinine, and carbon dioxide combining power will furnish further information concerning renal function. A scout film of the kidneys, ureters and bladder and excretory urograms will usually reveal the presence of a stone and will afford valuable information as to the functional activity of the urinary system. One should constantly keep in mind that a scout film giving negative evidence does not necessarily rule out the presence of a stone. Cystoscopic examination with differential determination of renal function by phenolsulfonphthalein or indigo carmine excretion will afford supplementary information. Retrograde pyeloureterograms are done if the diagnosis is uncertain or if further information is desired.

Treatment

The treatment of ureteral stone may be classified as (1) expectant, (2) instrumental, and (3) operative. In expectant treatment one awaits the spontaneous passage of the stone. Because of the proportionately large caliber of the ureter in young children, conservative treatment is often indicated. As a rule, in children, a stone may be expected to pass from the ureter to the bladder when its transverse diameter in millimeters is not over one third of the age. For example, a child 9 years old will pass a stone 3 mm. in diameter.[6] During this expectant treatment, water in abundance is prescribed. Codeine or morphine should be employed during attacks of ureteral colic. Regardless of the size of the stone, expectant treatment is contraindicated if migration of the stone is slow and extremely painful.

If the stone is small and its passage through the ureter seems likely, and if infection is absent or mild, instrumental dilatation of the ureter may facilitate its passage. Because of the small caliber instruments which must be used, ureteral dilatation may be carried out by the passage of two, three, or four small size 4 F. catheters side by side. The catheters are left in place for a few hours to make the dilatation more effective. Sterile mineral oil is then injected through one of the catheters to facilitate passage of the stone, and the catheters are then twisted and removed. If the stone fails to pass within two or three weeks and if little or no infection is present, ureteral dilatation may be repeated. More than two instrumental dilatations are not advisable. Manipulation of ureteral stones is not without hazard, particularly in the young.

Ureterolithotomy is indicated when (1) the stone fails to pass spontaneously; (2) if migration is slow and painful; (3) if serious renal damage or infection of considerable degree is present; and (4) if the stone is considered too large to pass. When ureterolithotomy is decided upon, a last minute scout film should be made to ascertain whether the stone has moved. The incisions employed in ureterolithotomy in adults can usually be applied in children. Having identified the stone at operation, the ureter just above should be compressed with the finger or a tape sling used to prevent losing the calculus. The ureter overlying the stone is incised longitudinally, and the stone removed. A small catheter is then passed to the

bladder and to the kidney to detect any previously unrecognized stone or other obstruction. The ureteral wound is closed with fine atraumatic interrupted sutures, care being taken that the ureteral mucosa is not included in the suture.

Follow-up studies should be carried out in all patients who have had urinary calculi. Urinalyses, tests for renal function, and roentgenologic studies should be done to determine if residual infection is present and to determine if there is any recurrence of stone formation. A dietary regime to aid in preventing any recurrence of stone is difficult to carry out in children as it usually results in an unbalanced diet for the growing child.

Report of Case

A. E., a 10 year old white boy, was admitted to the hospital on April 17, 1947 because of acute pain in the right side of the abdomen. A tentative diagnosis of acute appendicitis was made; however, the finding of numerous red blood cells in the urine prompted urologic consultation. Questioning revealed that he had had painless gross hematuria, without clots, on five occasions during the preceding month. Three days before admission there had developed a dull aching pain in the right upper quadrant which radiated medially. The pain increased in intensity and finally became sharp and colicky in character. At that time he complained of increased frequency of urination. All symptoms suddenly ceased for several hours, following which the dull, aching pain recurred, then disappeared completely. The remainder of the medical history was noncontributory.

Physical examination revealed a well developed, well nourished boy in no apparent pain. There was moderate tenderness in the right costovertebral angle and decided tenderness and a sensation of fulness in the right upper quadrant. No other positive physical findings were present.

Laboratory Data: Urine: Smoky; hydrogen ion concentration, 5.5; specific gravity, 1.018; 1 plus albumin; no sugar. Wet sediment, numerous erythrocytes; stained sediment, no pus, no organisms. Urine culture, negative. Blood: Red blood cells, 4,350,000; hemoglobin, 88 per cent; white blood cells, 11,800; neutrophils, 68 per cent; lymphocytes, 38 per cent; monocytes, 4 per cent. Phenolsulfonphthalein, intravenous, one hour and ten minutes, 60 per cent. Nonprotein nitrogen, 28. Serum calcium, 10. Serum phosphorus, 3.5. Kahn reaction, negative.

Roentgenograms of the kidneys, ureters and bladder and excretory urograms revealed a moderate hydronephrosis of the right kidney and a moderate dilatation of the upper one third of the right ureter. The middle third of the right ureter was not well visualized. The left kidney and ureter were normal.

Under ether anesthesia, cystoscopic examination revealed that the bladder mucosa was essentially normal. Smoky urine spurted from the right orifice, clear urine from the left orifice. Indigo carmine appeared at the left orifice in three minutes with good concentration and at the right orifice in six minutes with poor concentration and in eight minutes, fair concentration. A size 4 ureteral catheter was inserted into the right ureter, and an obstruction was encountered 9 cm. above the orifice, but the catheter was passed without difficulty into the kidney. Retrograde pyeloureterograms confirmed the findings of the excretory urograms. There was no demonstrable cause for the hydronephrosis. The catheter was left in place for three days for drainage of the kidney, then removed, as the parents refused any further roentgenograms at that time.

One month later urinalysis revealed few erythrocytes. Two months later, roentgenograms of the kidneys, ureters and bladder and excretory urograms revealed that the right kidney was much smaller, there being only slight dilatation of the pelvis and blunting of the calyces. The ureter was well outlined, and no filling defects were demonstrated. The patient was not seen again for three months. Five months after the original attack, he complained of severe colicky pain in the right side and was hospitalized. Retrograde pyelograms revealed moderate hydronephrosis of the right kidney, dilatation of the upper two thirds of the right ureter, and a filling defect, 1.2 cm. by .7 cm., in the lower one third of the right ureter. The filling defect was consistent with a stone. The stone was considered too large to pass spontaneously or to be removed by instrumental manipulation, and it was decided that ureterolithotomy was indicated.

Through an oblique, lower, right, abdominal incision, the ureter was identified. The ureter was thickened, and there was considerable periureteritis. The stone was isolated in the lower one third of the ureter and was removed without difficulty. A catheter was passed to the kidney and bladder without meeting obstruction. The incision was closed with three size 000 atraumatic sutures. Postoperative convalescence was entirely uneventful. Chemical analysis of the stone revealed calcium oxalate.

Roentgenograms of the kidneys, ureters and bladder and excretory urograms, two and four months postoperatively, revealed normal kidneys and ureters, and repeated urinalyses have given negative results.

Summary and Conclusion

Despite their rarity in children, ureteral calculi must be considered in the differential diagnoses when the cause of pain, pyuria, hematuria, or obstructive uropathy is being sought. Complete urologic examination must be carried out when these conditions exist. Undoubtedly, some attacks of colic in children are due to the passage of stones or clusters of crystals. Children suffering from urinary calculi are usually subjected to intra-abdominal exploratory surgery or are treated for months and years for so-called pyelitis or glomerulonephritis before the true cause of their symptoms is discovered.

The great majority of ureteral calculi will pass spontaneously into the bladder. If, however, severe infection or reduced renal function exists, if passage of the stone is slow and extremely painful, or if the stone is considered too large to pass, operative intervention is indicated.

A case is reported of a ureteral stone in a boy, aged 10, in which the cause of hydronephrosis and hydroureter could not at first be determined despite thorough roentgen studies. Apparently, the stone shadow was obscured by the pelvic bones. Later roentgenograms revealed a stone to be the cause of obstruction. It was considered too large to pass, and a successful ureterolithotomy was performed.

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Venereal Diseases: Diagnosis and Treatment

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Since the advent of penicillin many articles have appeared in the literature on the diagnosis and treatment of venereal diseases. It would be a task to cover the entire field; however, I should like to present some of the latest thoughts and clinical observations on this group of diseases.

Syphilis

Penicillin given in adequate amounts is a safe effective short term method of treating early syphilis. This short term administration, however, creates a lag between the completion of therapy and the alteration of the serologic response. In the days of standard therapy, the prolonged treatment periods permitted the observation of serologic reversal during the span of such treatment. Today, with penicillin, reversal occurs many months after therapy has been completed, and it is therefore imperative that physicians be familiar with the interpretation of the quantitative serologic test in order that they may intelligently diagnose and treat syphilitic conditions.

This lag with short term therapy has raised many questions among physicians as to the results of intensive therapy and the need for retreatment in their patients returning from rapid treatment centers or completing ambulatory therapy in their offices. It is important, therefore, that the patient who has completed penicillin therapy be observed once each month for a period of at least one year. In addition to the routine monthly blood test, which should be submitted for titered serologic testing, it is extremely important to observe clinically the site of the original lesion and to look for mucocutaneous relapses at such sites as the mouth, eyes, genitalia and skin.

Points of Emphasis[1-3]

1. A quantitative serologic test must be utilized in evaluating rapid treatment follow-up.

2. A base line prior to treatment is desirable.

3. The same laboratory should be used for all tests. (Do not attempt to evaluate the results of one laboratory against another, as different technics, different tests and differences in antigen sensitivity will give variable results.)

4. A one tube dilution difference, such as 1:1 dilution to 1:2 dilution or 1:2 dilution to 1:4 dilution, may be an observational error. In such instances the serologic test should be rechecked at weekly intervals.

5. The initial pattern of the serologic curve is not of prognostic value. A serologic reaction which becomes negative may revert to positive in ensuing months. A minimum of one year follow-up is imperative after the first negative reaction.

6. In early infectious syphilis, there is in most cases reversal to negative or a trend to low titer positives by the end of the sixth month.

7. A rise in the quantitative titer after intensive treatment warrants repeat tests at weekly intervals to ascertain whether serologic and clinical relapse is impending.

8. The monthly interval of observation is important, since an intervening decline and subsequent rise may be missed as illustrated in figure 1.

9. A substantial rise in the quantitative titer indicates a serologic relapse and is usually followed by a clinical relapse. In such cases the patient should be retreated immediately when serologic relapse is determined.

Director, Bureau of Preventable Diseases, Florida State Board of Health.
Presented before the Special Graduate Short Course, Duval Medical Center, Jacksonville, Sept. 13, 1948.

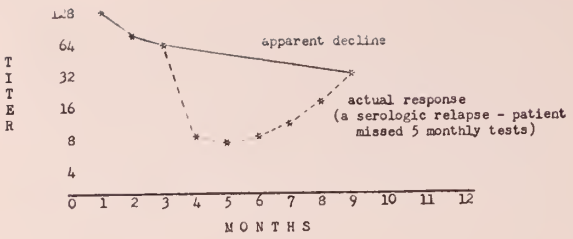


Figure 1

10. The longer the duration of a syphilitic infection, the greater the lag in the serologic decline.

11. The longer the duration of the infection, the less chance of complete reversal to negativity. In old syphilitic infections one will find more seroresistance or serologic fastness.

12. Every patient with a syphilitic infection should have an examination of the spinal fluid. This examination may frequently explain the cause of persistently elevated quantitative titers, if the spinal fluid test reveals involvement of the central nervous system.

Indications For Retreatment

1. If clinical mucocutaneous lesions recur at any time following rapid short term therapy—retreat. A primary chancre may recur at its initial site, and secondary symptoms may also recur.

2. If, in the absence of lesions, the quantitative serologic tests which have been declining show a leveling off at values above 1:4 dilution (16 Kahn Units) and this is maintained for six months—retreat.

3. If the quantitative titer which has been declining reverses its trend and shows an increasing value, weekly tests are indicated. (See figure 1.) If these confirm the rise—retreat immediately. This is a serologic relapse, and clinical relapse impends within a month.

4. If the quantitative titer declines to negative and begins to increase as confirmed by weekly tests after the rise—retreat. Although patients may have a negative reaction some months after rapid therapy, it is imperative that they be followed for one year with monthly tests since there may be a relapse even after negativity is obtained. The chances of such relapse, however, diminish rapidly beyond the sixth month of observation.

5. If treatment fails to alter a high initial quantitative titer and this original titer persists beyond the fifth month of observation, intensive therapy has been a failure—retreat.

Treatment

PRIMARY AND SECONDARY SYPHILIS.—For the past several years clinical experiments have been undertaken in the treatment of syphilis with penicillin. Cooperating clinics throughout the country have explored different treatment schedules in the management of early syphilis. Tabulated data presented by the cooperating clinics show the range of effectiveness of penicillin in the treatment of early syphilis to be in doses somewhere between 2.4 and 4.8 million units. The duration of treatment in days shows that it appeared to make no difference whether the doses were given in four, seven and one-half or fifteen days, as the net results were equally satisfactory. Likewise, it makes no difference whether the interval between injections is two, three or six hours when aqueous solution is used. Clinically, penicillin G is superior to any other form of penicillin in the treatment of syphilis. The use of penicillin G makes hospitalization a necessity; therefore, it is of utmost importance to the patient and to the physician that a treatment schedule be developed which would do away with the necessity for hospitalization. Since procaine penicillin and penicillin in oil plus aluminum monosterate show a detectable blood level for forty-eight to seventy-two hours, it appears that penicillin in oil and beeswax is on the way out, to be replaced by other preparations.

Primary and secondary syphilis can now be effectively treated on an ambulatory basis by using procaine penicillin or penicillin in oil with aluminum monosterate in one of two ways: 1 cc. (300,000 units) daily for fifteen days, total 4.5 million units; or 2 cc. (600,000 units) daily for eight days, total 4.8 million units. There is no material advantage in using arsenic and bismuth with penicillin over using penicillin alone.

Moore[2] is of the opinion that patients who have been treated with penicillin and have experienced a relapse should have arsenic and bismuth added to their penicillin treatment. Others, however, prefer giving the patient another course of penicillin therapy, usually doubling the total amount given. Mahoney[2] and his group saw no reason to employ such a dangerous, unpleasant, disagreeable drug as arsenic in the treatment of early syphilis when penicillin is equally effective. Penicillin therapy does not offer a "sure-fire" cure for syphilis. Relapses

may occur, but a relapsing infection can be retreated quickly and effectively by employing a larger dose of penicillin. The rapidity and ease of administering penicillin and the almost negligible toxicity make it a particularly valuable drug.

Early Latent Syphilis (Duration Less Than Four Years).—The same treatment schedule employing procaine penicillin as outlined for early infectious syphilis may be used for the latent form in the early stages. Patients given rapid therapy for early latent syphilis of less than six months' duration may expect a serologically negative reaction within one year after treatment in the majority of cases. The persistence of low quantitative titers of 1:2 (8 Kahn Units) or less in such patients for more than one year is not an indication for further treatment. In patients with latent syphilis of more than six months' duration as a rule it requires more than one year to obtain a completely seronegative reaction. In general, the longer the duration of latent syphilis, the longer the time required for the serologic test to give negative results. Retreatment is not indicated in such patients unless the follow-up serologic titer shows definite and substantial rises from previous levels.

Late Latent Syphilis (Duration More Than Four Years).—The aim of treatment in late latent or late syphilis in general is not to obtain negative serologic reactions, but to prevent further progress of the disease. Procaine penicillin or penicillin in oil and beeswax, given 600,000 units intramuscularly every twenty-four hours for eight to ten days with the total dosage 4.8 to 6 million units, is the recommended therapy for this stage of syphilis. Quantitative serologic tests are valuable in the follow-up of such patients. If decidedly substantial rises in serologic titer occur, additional treatment is indicated. Present knowledge indicates that patients who continue to have a gradual drop in titer over a period of years require no further treatment.

Cardiovascular Syphilis.—Little is known as to the effectiveness of penicillin in cardiovascular syphilis. If penicillin is utilized, it should be started after the patient is prepared for eight to ten weeks with bismuth therapy. The total dosage of penicillin should be large (6 or more million units) and duration of treatment prolonged over fifteen or more days. Moore[2] has shown that one can produce, both in early syphilis and neurosyphilis, multiple Herxheimer reactions by means of the administration of small doses of penicillin. He stated that it is of practical importance to note, especially in cardiovascular syphilis, that the Herxheimer reaction cannot be avoided by initiating treatment with tiny doses of penicillin, but in doing so one may subject a patient to multiple reactions and, if there is real danger involved, leave him in a worse state trying to avoid trouble than if one had plunged boldly ahead and given him a good-sized therapeutic dose to begin with.

Neurosyphilis.—Six to 10 million units of penicillin (600,000 units daily) intramuscularly should be administered over a period of eight to twenty days' time in asymptomatic invasion of the central nervous system. In paresis and tabes dorsalis, 10 to 20 million units of penicillin administered over a period of ten to twenty days is recommended. The literature is replete with accounts of the advantages of penicillin alone or penicillin combined with fever therapy in the treatment of severe parenchymatous types of neurosyphilis. Kierland, O'Leary and Underwood[4] concluded, from a review of the literature and their own experience, that a combination of malaria and penicillin is the treatment of choice in severe types of neurosyphilis. Dattner[5] and Stokes and his associates[6] agreed that equally good results are obtained by the use of penicillin alone. I am inclined to agree with the latter opinion and therefore recommend penicillin alone.

In syphilis of the central nervous system, the spinal fluid findings are the only reliable guide to evaluating the therapeutic efficacy of penicillin. The presence of an increased number of cells in the spinal fluid six months after treatment, accompanied by a rise in the total protein or globulin or a rise in the spinal fluid quantitative titer at any time following treatment, indicates the need for additional treatment. Thus, the spinal fluid examination is to neurosyphilis what the serologic test is to the other stages of syphilis. All observers agree that the first abnormal finding of the spinal fluid to become normal is the cell count. The protein value, the colloidal gold changes, and the complement fixation reactions decrease gradually, usually in the order given. In some patients it may require five or more years before the serologic reaction and the colloidal gold curve become completely normal.

Syphilis of Pregnancy.—Penicillin in antepartum syphilis is nearly a complete success in the protection of the fetus. In the past, repeated recommendations have been made that the syphilitic mother should be given adequate treat-

ment in every pregnancy regardless of the amount of previous treatment she might have received. Most syphilologists believe that this is no longer necessary, but if there is reason to suspect that a patient will not return faithfully for serologic tests, it is certainly safer to retreat when the diagnosis of pregnancy is made. For some yet unexplained biologic reason, it appears desirable to administer penicillin G aqueous solution, 50,000 units intramuscularly every two hours, ninety-six doses, a total of 4.8 million units during pregnancy. This schedule, of course, requires hospitalization, and if such is impossible, then satisfactory results can be obtained by using the treatment schedule outlined under primary and secondary syphilis. Nonsyphilitic babies may be obtained regardless of the period of gestation in which penicillin therapy is started. If relapse occurs during the antepartum period, a healthy baby may be obtained if retreatment is instituted promptly. It is imperative that a quantitative serologic test be taken at monthly intervals or less during the antepartum period in order to detect evidence of serologic or clinical relapse.

Goodwin and Farber[7] and Speicer, Flaum, Moon-Adams and Thomas[8] studied large groups of patients with varying types of syphilitic infection and observed them through subsequent pregnancies in which further antisyphilitic treatment was purposely omitted. The data from these studies indicate that it is not necessary to administer antisyphilitic treatment to a syphilitic woman during every pregnancy and that there is a high degree of probability that the infant will be normal if maternal treatment is withheld; the treatment is advocated during pregnancy only for those patients who have not shown satisfactory progress. Further treatment during pregnancy may be omitted if the following requirements are met: (a) when the mother has previously received 4.0 Gm. or more of an arsenical together with bismuth or 2.4 or more million units of penicillin; (b) when the previous treatment was administered during a previous pregnancy or during a nonpregnant interval; (c) when the mother shows no signs of active syphilitic infection; and (d) when the mother has a negative serologic reaction or if still seropositive, the titer is of low dilution. If the quantitative blood titer rises at any time during pregnancy, additional treatment is indicated; if it remains at a stationary low level, no additional treatment is necessary.

CONGENITAL SYPHILIS.—The desirable treatment for early congenital syphilis (infants) is the use of penicillin G in aqueous solution every two hours intramuscularly. The total dosage is calculated on the basis of 100,000 units per pound of body weight divided by 120 doses.

Late congenital syphilis is treated by the same schedule outlined under primary or secondary syphilis.

INTERSTITIAL KERATITIS.—Uniformly good results are not always obtained with any therapeutic schedule in the treatment of interstitial keratitis due to late congenital syphilis. Various forms of treatment have been advocated with more or less the same results; that is, in occasional cases there is dramatic cure, in others moderate improvement, and in significant numbers little or no improvement. Routine antisyphilitic therapy with the arsenicals and bismuth has given only fair results. London and Noojin[9] in a series of cases used combined fever and penicillin therapy. The fever therapy was induced with a typhoid vaccine preparation. Bidaily injections of typhoid vaccine were used to induce fever, plus 4 to 6 million units of penicillin. They concluded from their preliminary studies of this series that this treatment schedule is not highly satisfactory in terms of ultimate clinical results. From the results of available therapeutic regimes for the treatment of interstitial keratitis, it is concluded that an urgent need for newer and more effective methods is indicated.

OPTIC NERVE ATROPHY.[10]—The most efficacious treatment of primary syphilitic optic nerve atrophy at the present time is considered to be malarial therapy aided by a course of concomitant and subsequent injections of penicillin with 5,000,000 units in each course.

Other Venereal Diseases[11]

GONORRHEA.—The most widely employed treatment schedule for acute or chronic gonorrhea at the present time is a single intramuscular injection of 300,000 units of penicillin in oil and beeswax, procaine penicillin, or penicillin in oil with aluminum monosterate. Some observers report a good rate of cure with a single intramuscular injection of 0.2 Gm. of streptomycin in aqueous solution and almost 100 per cent rate of cure with a single dose of 0.3 Gm.

The treatment of gonorrhea is in itself not much of a problem. The biggest problem in the

control of gonorrhea is the diagnosis, particularly in the female. If, however, the physician's degree of suspicion is elevated, in a good many of the questionable cases treatment for gonorrhea will be given even though laboratory findings are not conclusive. If the morbidity of gonorrhea infections is to be reduced, physicians must exert more effort to obtain contacts, particularly female contacts of male gonorrhea patients.

When treating patients for gonorrhea with a single intramuscular injection of penicillin, one should be aware of the fact that this small dose is sufficient to delay or mask the development of primary or secondary syphilitic lesions for as long as three to nine months when a dual infection has been contracted. It is well when treating patients for gonorrhea to make inquiry of these patients to see if they had any febrile reactions from the single injection of penicillin. If such a patient had a febrile reaction two or three days after treatment, it was probably due to a Herxheimer reaction, and this patient should be carefully observed at monthly intervals for the next three to nine months with quantitative blood tests to detect the development of delayed primary or secondary syphilis.

Ophthalmia Neonatorum.—The state law of Florida requires the instillation of 1 per cent silver nitrate in the eyes of newborn infants for the prevention of ophthalmia neonatorum. Many articles have appeared in the literature about the use of penicillin in concentrations of 2,500 units per cc. to prevent the development of this disease, but this method requires the instillation of penicillin drops in the eyes for at least four days and to date investigators have not been convinced that this method is superior to the single instillation of silver nitrate; therefore, the use of penicillin drops is not yet recommended.

Granuloma Inguinale.[12]—The use of streptomycin in the treatment of granuloma inguinale is highly effective. The Rapid Treatment Center at Melbourne has treated approximately 500 patients, who received an average of 20 Gm. each. In early cases, healing of the lesions was rapid, and Donovan bodies disappeared in six to eight days. Lesions of longer duration required from 20 to 40 Gm. of streptomycin, and a longer time was required for the lesions to heal.

Chancroid.—The sulfonamides still remain the drugs of choice in this disease. Streptomycin may display some curative value, but penicillin is ineffective.

Lymphogranuloma Venereum.—Sulfonamides are of some value in the treatment of this condition, particularly in the acute phase. No antibiotic has proved of definite value in this virus infection.

Conclusion

An attempt has been made to cover some of the latest advances in the diagnosis and treatment of venereal diseases. Although there now are better therapeutic weapons with which to combat most venereal diseases, it is evident that these diseases will not be abolished at any time in the near future unless the sexual behavior of human beings undergoes radical changes or some form of immunization is developed to prevent these infections.

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to Be Published

in June Issue

The Role of Quinine and Urea Hydrochloride in Proctology

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It is regrettably true that, in so far as we know, the injection treatment of hemorrhoids was originated by quacks who exploited it to such a degree that in certain localities the stigma still lives. According to Andrews,[1] this treatment was originated in 1871 by an "itinerant charlatan" of Clinton, Ill. The method and drug used are not clear, but it appears that the secret formula was imparted for a fee which entitled the purchaser to exclusive rights in a limited territory. It seems likely that phenol was at least one of the active ingredients and that hemorrhoids prolapsing outside the body were the type usually treated, as suitable specula were not then available. Treatment was intended to slough off the hemorrhoidal masses. There were, no doubt, many unfortunate complications from this sort of treatment administered by such poorly trained and ill-equipped practitioners, but the fact cannot be overlooked that some patients were cured. The ethical practitioner of that day had only surgery to offer relief for the "pile sufferer," and for one reason or another this was refused by many. At any rate, the method survived, but it was almost the exclusive property of the quack until 1916.

In the first decade of the present century quinine and urea hydrochloride were widely used as a local anesthetic, and it was well known that its use was followed by a fibrous infiltration of the deeper tissues and frequently by sloughing of the skin or mucous membranes. In April 1913, Dr. E. H. Terrell[2a] first used this drug in the injection treatment of internal hemorrhoids after rationalizing that a cure could be expected to follow the artificial creation of a fibrosis within the hemorrhoid, care being taken to avoid the production of a slough. He was successful with this therapy, and in 1916 read before the American Proctologic Society his first paper on the subject, in which he gave his experiences with the method. He had varied the concentration of the drug from 1 to 20 per cent and concluded that 5 per cent was the most satisfactory. He also outlined the indications and contraindications for treatment as well as the technic, which have been but little changed since, though at the time his observations elicited sharp criticism including implications of quackery. He had, however, from the beginning passed on his idea to certain outstanding proctologists scattered over the United States, and their voices were now heard in his behalf. Each year there have been added converts until now the method is an accepted form of ethical treatment, advocated by leading proctologists the world over,[3-14] though there are still those who, from lack of experience or failure to use the proper technic, condemn the procedure.

Hemorrhoids are tumor masses of the anus and rectum composed of varicose veins, which here, as elsewhere, are thin-walled, dilated, elongated and tortuous. The tissues drained by such veins show changes characteristic of chronic, passive congestion with loss of elasticity, increased fragility and lowered resistance leading to erosion and ulceration. The objective of the modern injection treatment is the gradual obliteration of the hemorrhoidal tumor without the production of a slough, and only hemorrhoids within the body are considered suitable for treatment. Injection of quinine and urea hydrochloride into an internal hemorrhoid produces an immediate hemostatic effect which is followed by a fibrous tissue infiltration which obliterates the varicosities, causing the hemorrhoidal mass to atrophy and finally disappear entirely.

We do not recommend the use of quinine and urea hydrochloride for the treatment of external hemorrhoids as the drug in the strength used is strongly acid in reaction, having a hydrogen ion concentration of 2.6. If injected beneath the skin it produces intolerable pain. Injection, however, is the treatment of choice for uncomplicated internal hemorrhoids,[2b,4,7,11,14,15] which constitute 25 per cent or more of all hemorrhoids; and if treatment is competently given, complete and permanent cure will follow in approximately 100 per cent of cases. If internal hemorrhoids are pro-

Read before the Florida Proctologic Society, First Annual Meeting, St. Augustine, April 11, 1948.

lapsed, they are first replaced within the rectum and then injected. Strangulation of internal hemorrhoids with thrombosis and/or necrosis is generally an indication for surgery, but in many cases strangulation may be reduced in the office, after which an injection is made at a somewhat higher level and a pressure dressing applied to the anus. Injection is the method of choice in the treatment of rectal prolapse of infants and children, and it is rare that more than one or two treatments are necessary to produce symptomatic cure.

When both internal and external hemorrhoids are present, or when internal hemorrhoids coexist with fistula, abscess, fissure, suppurative cryptitis, anal stenosis or polyps, surgery is indicated[2c,6,9,15,16,17] and should, of course, be performed, with removal in most cases of the hemorrhoids at the same time other pathologic conditions are corrected. Rectal surgery when properly performed is perhaps more satisfactory than surgery in any other part of the body, and injection is not intended to replace surgery except in the treatment of uncomplicated internal hemorrhoids.

In addition to treatment aimed at permanent cure, there is properly a wide field in which it may be used palliatively.[17-19] The proctologist who is not qualified to administer it denies much comfort to the patient for whom surgery constitutes an undesirable hazard.

All of us see from time to time patients who for reasons of their own simply will not submit to an operation when we strongly advise it. There are others who will eventually undergo surgery, but desire temporary relief before this can be arranged. Then, too, the injection treatment of internal hemorrhoids can usually be expected to prove beneficial in such nonsurgical conditions as pruritus ani, superficial anal fissures and certain cases of cryptitis. The elimination of internal hemorrhoids will lessen the frequency and severity of attacks of acute recurring external thrombotic hemorrhoids.

Before attempting to use the method, one must become expert in anorectal examination and diagnosis. The doctor who desires to learn the technic of injection so that he can inject every patient having an anorectal complaint, regardless of pathologic change, merits our contempt. The proctologist has the advantage over many specialists in other fields in that he can both see and/or feel a high percentage of anorectal pathologic conditions, and is therefore enabled to arrive at an exact diagnosis, while at the same time avoiding many errors inherent in indirect methods of examination. Failure to understand thoroughly the anatomy and pathology, or to exercise judgment in the selection of cases, can only be followed by disaster to the patient, grief to the physician and disrepute to the method.

After the examination, it is our custom to discuss the findings with the patient; we tell him frankly what treatment is necessary and what results may be expected. Often he is told that complete and permanent cure will require an operation, but that injection treatments will give prolonged temporary relief. Thus the patient makes his own decision, and we are willing to do as he chooses, but we scrupulously avoid encouraging him to expect a cure when a pathologic state exists which we know from experience cannot be completely eradicated without surgery. In our community, hospital beds are at such a premium that often admittance is gained only after one has had his name on the waiting list for a considerable period of time. This inconvenience leads us, in many cases, to administer one or two injections to arrest bleeding and/or protrusion of internal hemorrhoids while awaiting hospitalization. Patients thus treated are frequently so satisfied with the prompt symptomatic relief obtained that they think an operation is really unnecessary even after limitations of injection therapy are once more explained to them.

If a patient has internal hemorrhoids that are considered entirely suitable for injection treatment, he is so informed, but warned that treatment should be continued until he is pronounced cured. It is usual for the first treatment to stop bleeding and protrusion, even though these symptoms may have been present for years. Such a patient is apt to conclude that he is cured, when we would only classify his condition as arrested; and if treatment is stopped at this point, a return of the symptoms may be expected later on. Treatment should be continued until the hemorrhoidal masses have entirely disappeared; the number of injections necessary to accomplish this result varies, but four to eight will generally suffice. Injection is made near the center of the internal hemorrhoid, well above the mucocutaneous line, care being taken to avoid overdistention, or placing the fluid too superficially. Failure to observe these precautions will result in pain or slough. All hemorrhoids are injected at each visit, and the optimal time interval between visits is one to two weeks, but within reasonable limits this can be adjusted to suit the convenience of the patient. Occasionally patients come from considerable distances and remain in

town taking treatments on three or four consecutive days. This intensive treatment is likely to be followed by induration in the hemorrhoid, which is not often encountered when treatments are more widely spaced. When induration is present, injection should be deferred until this has subsided, lest sloughing occur.

Treatment is of course completely ambulatory except that the patient is instructed to keep quiet for an hour after the injection is made. This precaution is taken to lessen the local discomfort which so often will begin in about thirty minutes and last for another thirty to sixty minutes. The only alarming complication that we have seen following the injection of quinine and urea hydrochloride after twelve years daily use of the drug has been a rare case of quinine sensitivity with vasomotor collapse. Other less serious sensitivity reactions occasionally occur. There have been no deaths, infections, hemorrhages, strictures, fistulas or sloughs in our experience, though on rare occasions we have seen pin point necrosis in the mucosa, of which in most cases the patient, himself, was unaware. In one patient with benign prostatic hypertrophy urinary retention developed. Occasionally, serious complications incident to the injection of hemorrhoids with quinine and urea hydrochloride have been reported, [10,20,21] but these must be attributed to incorrect diagnosis, nonobservance of the contraindications, or faulty technic.[2d,3] If internal hemorrhoids are especially large or prolapse with ease, it is our custom to place the injection even higher in the superior pole of the hemorrhoid than otherwise, and after treatment a small fluff of dry cotton is applied to the anus and held firmly in place with a T binder for several hours. The patient is instructed to postpone defecation for twelve to twenty-four hours after the injection. By taking these precautions, strangulation has been virtually eliminated as a complication of the injection treatment of hemorrhoids.

Conclusion

Thirty-five years have passed since quinine and urea hydrochloride were first used for the injection treatment of internal hemorrhoids, and in our experience it has been the safest and most efficient remedy advocated for this purpose. We believe that failure to obtain a lasting cure in suitable cases of uncomplicated internal hemorrhoids is due to inadequate treatment and that complications are due to errors of judgment in selection of cases or to poor technic.

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500 Medical Arts Building.

Proceedings of Seventy-Fifth Annual Meeting

Scheduled for Publication

in the June Issue

ABSTRACTS OF MEDICAL ARTICLES

MODIFIED NICOLA OPERATION FOR CORRECTION OF RECURRING ANTERIOR DISLOCATIONS OF THE SHOULDER. By Martin Mangels, Jr., M.D., and Charles A. Robinson, M.D. South. M. J. 40:784-786 (Sept.) 1947.

A series of 11 selected cases is reported in which the authors used most successfully a procedure which they, as general surgeons in military service rather than orthopedic specialists, evolved for recurring anterior dislocation of the shoulder. Their method, which they describe, preserves the good qualities of the Nicola operation and yet avoids severing and resuturing of the tendon of the long head of the biceps muscle as is performed in the classic Nicola technic.

They observe that surgery is contraindicated if the skin is not absolutely clean and healthy; that their operation will not be adequate in the presence of a complicating pathologic condition in the glenoid, such as erosion of the anterior lip; and that excellent facilities for physical therapy must be available and intelligently applied during both the preoperative and postoperative periods.

TECHNICAL CONSIDERATIONS IN ADEQUATE TRANSURETHRAL PROSTATIC RESECTION. By A. Fred Turner, Jr., M.D., Louis M. Orr, M.D., and Joseph C. Hayward, M.D. South. M. J. 40:296-303 (April) 1947.

The technical requirements considered necessary in performing adequate transurethral removal of the prostate in the light of new and improved equipment and recent important advances are presented. A series of 105 cases with a mortality rate of zero is reported. The particular advantages of transurethral prostatic resection include almost complete absence of shock and discomfort and the short period of hospitalization.

UROLOGIC COMPLICATIONS OF PELVIC FRACTURES. By Arthur J. Butt, M.D., and Thomas D. Moore, M.D. South. Surgeon 13:508-520. (Aug.) 1947.

A series of 126 cases of fracture of the pelvis is reported. In 30 of these cases there were urologic complications, occurring with greatest frequency in young Negro men as a result of multiple pelvic fractures sustained in vehicular accidents.

Urologic injuries consisted of ruptured urethra in 11 cases, ruptured bladder in 5, contusion of the bladder in 2, hematoma of the bladder in 2, contusion of the kidney in 2, and hematuria of undetermined origin in 8. In these 30 cases the mortality rate was 37 per cent. In the 96 cases of pelvic fracture without urologic complications the mortality rate was 6 per cent.

Methods of diagnosis, late complications and treatment of urologic complications are reviewed. Urologic diagnostic measures, complications and their management are discussed.

CUTANEOUS TESTING IN A CASE OF EXFOLIATIVE DERMATITIS CAUSED BY PENICILLIN. By Joseph Farrington, M.D., and Joseph Tamura, Ph.D. Arch. Dermat. & Syph. 56:807-811 (Dec.) 1947.

A case is reported in which there was severe dermatitis exfoliativa in a white man aged 78 after parenteral treatment with penicillin for lobar pneumonia. A warning generalized maculopapular eruption was followed by the severe cutaneous reaction when penicillin therapy was continued because of the severity of the pneumonia.

Extensive cutaneous tests made later resulted in urticarial and tuberculin types of reactions to different commercial brands of penicillin and to one sample of crystalline sodium penicillin K. Quantitative testing with graded dilutions revealed cessation of cutaneous response between 2.5 and 0.25 units. Tests with trichophytin, gliotoxin and streptomycin elicited negative results except for an intradermal test with trichophytin, which gave positive results.

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The Journal of the Florida Medical Association

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Association Officers for 1949-1950

Dr. Walter C. Payne of Pensacola, president of the Association, will be assisted by an able group of officers during the ensuing year. They were elected and inducted into office with Dr. Payne at the last meeting of the House of Delegates which was held at Belleair on April 13.

Dr. Herbert E. White of St. Augustine, who served the Association last year as the first vice president, was elected to understudy Dr. Payne as president-elect. Assuming office with them are Dr. David E. Murphey, Jr., of Tampa, first vice president; Dr. M. Eldridge Black of Clearwater, second vice president; Dr. John M. Butcher of Sarasota, third vice president; Dr. Robert B. McIver of Jacksonville, secretary-treasurer, and Dr. Shaler Richardson of Jacksonville, editor of The Journal. Dr. McIver is beginning his sixth year as secretary-treasurer. Dr. Richardson has served nineteen years as secretary-treasurer, twenty-one years as editor of The Journal, two years as president-elect, and one year as president. He is entering his twenty-second year as editor.

Dr. Payne has completed his committee assignments for the ensuing year and they are published on the preceding page in this issue of The Journal. The progress of the Association in the months ahead rests with the new officers and those who have accepted the responsibility of serving on a committee.

The Proceedings of the Seventy-Fifth Annual Meeting are scheduled to appear in the June issue of The Journal. Included will be reports of officers and chairmen of committees, actions of reference committees, business of the House of Delegates and the General Sessions, and programs of the Scientific Assemblies.

Medical Practice in Great Britain

Conflicting reports today make it difficult for the average person to obtain a clear picture of the true state of medical practice in Great Britain. The position of the government since it plunged into the maelstrom of socialized medicine, the plight of the people as a whole, and the predicament in which the medical profession finds itself are, however, coming to light.

That all is far from well in Great Britain seems certain and that we have incontrovertible data available on the subject now likewise seems sure. Also, that we should make these data available to all physicians and the entire general public seems imperative.

Dr. William H. Sweet, Assistant Professor of Surgery at the Harvard Medical School, has spent more than six years in England—two years as an Oxford medical undergraduate, four years in London and Birmingham during the war as a practicing surgeon employed by the Ministry of Health, and a further recent period of work in that country. Few will deny that he is a brilliant surgeon and a careful, painstaking observer and compiler of facts.

In the past, Dr. Sweet had assumed that a faculty member of a teaching hospital staff could be but little affected by bruited changes, but recent observations by him on the status of physicians in Great Britain sharply challenged those notions. What he saw during a recent period of work on one of the active services of a large English hospital jarred him severely in his complacency. His article is a series of personal impressions which are convincing and which appear to be entirely fair.

Writing in the February 3 issue of The New England Journal of Medicine, Dr. Sweet, at the outset, points out that items of legislation which came into force in 1948 were only the culminating step in a series of laws which began in 1912 with an act which set up a system of compulsory health insurance for nearly all wage earners. In 1929 a local government act increased the number of hospital beds operated by the government, and an act of 1936 opened those institutions to the entire population whether able to pay or not. During World War II, the British Government built numerous hospitals, employed nearly all the physicians remaining outside the armed forces, and contributed notable financial support to the privately operated and endowed hospitals of the country. The wartime level of taxation and the rising costs of living made it apparent that there would not be sufficient donors to support privately endowed hospitals after the war and that a major reorganization of medical practice would be needed. Conferences between the medical profession and the Minister of Health in Mr. Winston Churchill's Coalition Government resulted in tentative agreement on a service to cover all aspects of medical care for almost the whole nation. In 1945, however, when the Labour Party came into power, this agreement was ostensibly scrapped by Mr. Aneurin Bevan, the new Minister of Health. He announced that he would present a measure to the Parliament without bothering to have full discussion with any representative of the British Medical Association. The dispute which occurred as a result of this high-handed maneuver is fresh in the minds of all.

Major points which Dr. Sweet makes are:

1. The physician in general practice in England today is swamped by a volume of work that makes it possible for him only rarely to take a clinical history or make a thorough physical examination in the fashion that is attempted in this country. The British general practitioner now must see in the course of a single day an average of at least 50 patients if he has the average panel of 2,000 persons and 100 patients if he has the maximum panel of 4,000.

2. The load in England appears to arise not from a shortage of physicians there, but because the physician is expected to carry out many functions that Americans would not consider a part of their task. Many people with minor complaints wishing to obtain medicine, which is provided free of charge with the doctor's prescription, sit in his office and wait for a consultation and handout. This free conversation with the doctor and free medicine appear to be increasing the already large number of psychoneurotic and hypochondriac patients.

3. The Labour Government's many restrictions on the lives of the people result in a large number of appeals to the doctor for escape. The employee may not be absent from work without a valid excuse, and a note from the physician is the easiest kind of justification to present. The patient reports to his physician that he has been sick with diarrhea for two or three days, and the physician, unable to prove or disprove the statement, signs a form he has ready for the occasion. Likewise, many people who wish to evade the food-rationing restrictions seek a doctor's certificate of medical need for more eggs, meat, cheese, milk and so forth. There appears to be a limitless number of types of requests for housing, heating, transportation and domestic equipment. The building of an additional room on a house, the purchase of more fuel or more electric heat, the ownership of a car or more gasoline for it—even the buying of a hot water bottle—require governmental permits or are facilitated by governmental priorities, one avenue to which is a physician's certificate of medical need.

4. There is an extreme paucity of special diagnostic facilities at the general practitioner's command. Even routine blood counts are difficult to obtain. Almost all the facilities are in hospitals and are already overtaxed with work from the hospital itself.

5. The Labour Government has announced that it is proposing to set up so-called health centers in which several doctors will have their offices and at which there will be a diagnostic laboratory. No such centers have been built, however, nor are any being projected for the immediate future.

6. The so-called free care extends to the dispensing of braces, eyeglasses, arch supports and girdles. The patient tries to get from the general practitioner whatever may appear a handy thing to have about, but if he is balked at this level, he may demand to see a consultant.

7. The paucity of consultants, serious before the war, has not been alleviated, despite the fact that increasing knowledge makes the need for them greater. The waiting list on the neurosurgical service where Dr. Sweet worked was such that a

patient with a presumed brain tumor had to wait about three months before he could enter the hospital. Numbers died before they reached the top of the list.

8. An example of the disadvantages of bureaucracy was Dr. Sweet's experience when applying to the Ministry of Health for certain special instruments to perform an operation by a method untried prior to that time. The whole project was explained somewhat in detail, and the letter of request received a prompt postal reply promising consideration. Eight months later, long after Dr. Sweet had obtained the needed articles from a private source, he had a letter declining the request on the grounds that the instruments were not part of the usual neurosurgical setup.

9. While men in hospital training for consultant posts are to be paid salaries after the internship period which are somewhat higher than those paid by the major teaching hospitals in this country, Dr. Sweet knew several consultants with extended, complete postgraduate training in a surgical specialty whose salaries were about $2,500 per year after income tax reductions. That startling figure is less than the amount paid a skilled mechanic in England working far less "overtime" than those surgeons. Everyone of the skilled laborers in a factory operated by the father of one of those surgeons had a higher income than the surgeon had after fifteen years of higher education and postgraduate training and experience.

Dr. Sweet believes that one crucial feature of the difficulty in England is that the responsibility for being healthy and economically self sufficient has been shifted from the patient to his physician. He wishes that the medical profession knew enough about human personality in health and disease to shoulder that responsibility, but he is convinced that he at least does not. All physicians have seen striking examples of protracted convalescence that was being paid for by someone else, in contrast with brisk return to activity in patients with the same disorder who were determined to lead active lives again at the earliest moment. Yet, how can the doctor, who unfortunately cannot feel the patient's pain, tell whether a headache that allegedly persists after a fracture of the skull, or a back that goes on aching after a protruded intervertebral disc is removed, should be treated by a prompt return to work or some financially compensable and less arduous task?

After having his statements checked by four English physicians now in this country, Dr. Sweet concludes that the sorry plight of our British colleagues appears to be due to their having been compelled to accept terms imposed by nonmedical members of the nation. Had they analyzed the defects in their system, presented a well conceived plan for improvement, and then stood fast against ill advised changes, the British people might now be receiving better care and the physicians might be happier about their working milieu. The purpose of his article will be grossly misconstrued if it is considered an argument against any change in the present organization of the medical profession in the United States. The thesis is, on the contrary, that changes must occur and that the problem should be analyzed and the most logical type of reorganization effected.

Protecting the Minority

"Must we go socialist, as they did in Britain, where monopolies were not checked, cartels restricting trade have long been the order of the day, price-fixing has always been legal, and where, in fact, they never had free enterprise as we know it?" To this question Henry J. Taylor[1] in a recent radio address made the emphatic reply that such an assumption is a lie and a foolish one. One has only to read "Medical Practice in Great Britain" in this issue of The Journal to realize how much more foreign to this nation, the last firm, untouched foothold of freedom in all the world, than to the British people, now smarting under its evils, the socialist system of medicine or anything else would be.

This noted economist, author and journalist set forth clearly for his nationwide radio audience the case of 180,000 practicing physicians in this country, most of whom protest that socialized medicine would cost them their individual independence and make them merely wards and puppets at the mercy of Washington. In answer to these objections Mr. Oscar Ewing, Federal Security Administrator and chief exponent of socialized medicine, contends that the effect of socialization on the few doctors individually, only 180,000 of them, is unimportant, compared to the total population of the country—unimportant, that is, compared to what he thinks will be the effect on the population. A strange brand of Americanism—that.

1. Taylor, Henry J.: "Socialism a Politician's Paradise" (talk number 314), one of a series of radio talks on his program, Your Land and Mine.

The principle involved goes even deeper than doctors, Mr. Taylor points out, for a doctor is an American citizen and his individual rights are no less important because he is outnumbered. The American Republic is obligated beyond question to protect the minority—fully as much obligated as to respect the majority. "What legal right," this author asks, "has Mr. Ewing or anybody else to tell a doctor where he will work, in what community or why he will practice medicine, how much or how little he is to learn, what he is to charge for his talents, whom he is to treat, and where he is to treat them? It is neither moral nor just to disregard the honest, individual rights of one single man or woman or enterprise in this nation on any claim that to do so is for the good of a majority. That's totalitarian talk, this brushing-off of the rights of doctors."

Mr. Ewing's argument may well be blown right out of the water on the grounds of straight plain Americanism, as Mr. Taylor suggested. It would appear that the Federal Security Administrator has his countries mixed. America is not to be confused with Russia or Germany or Britain. What did the few assassinated wheat farmers of the Ukraine amount to, compared to the whole population? That was Stalin's argument. What did a handful of Jews—a mere 600,000—amount to, compared to 80,000,000 other Germans? Nothing! So argued Hitler in support of his national socialist government. Socialism in principle counts only the majority—the big numbers of people. As played by politicians in practice, it is basically a "numbers racket," said Mr. Taylor wisely, and a cruel one, at that. The small numbers do not count—even here.

"Let Mr. Ewing lay his socialist hand on one single doctor, and he will do so to your peril—whoever you may be and whatever work you may do—and to the peril of this country. For if doctors can be socialized, why cannot dairymen be socialized? More people need milk every day than need doctors. . . . If socialization of doctors is good for society—no matter how bad it is for doctors themselves—why isn't socialization of anything equally good for society? The answer is that socialization *isn't* good for society—that it finally turns out simply to be a politician's paradise." So warned Mr. Taylor.

Surely every thoughtful citizen—let alone doctor—will concur in the opinion of this keen observer that the whole idea that political control of our lives and work is the trend of the future should be retired into the obscurity from which it is a pity it ever emerged. Likewise meriting hearty concurrence is his statement that "the number-one challenge for statesmanship, in government, in business and in labor, is to interpret, and improve and advocate the independence from political control of the professions, of business and of working people, farmers, artists, students and doctors—not just once in a while, but day after day. . . ." The time for medical statesmanship of the highest order is now.



Physicians for the Armed Forces

Physicians now on duty with the armed forces and their families are bombarding the American Medical Association with letters regarding the possible retention of these physicians on active duty owing to the urgent need for medical officers. Most of them will soon complete two years of active military service following the government-sponsored and supported A. S. T. P. and V-12 medical training during the war.

The efforts of the Secretary of Defense to stimulate voluntary enlistments by the 8,000 civilian physicians who received all or part of their professional training at government expense and who saw little or no military service are heartily supported by the American Medical Association. In addition to this number, there are 7,000 physicians who paid for their own education, but who were deferred from their wartime draft to continue their medical education.

Said Dr. James C. Sargent of Milwaukee, the chairman of the American Medical Association Council on National Emergency Medical Service: "It is the moral obligation of these men to volunteer their services so that those doctors now on active duty, who have met their obligation following government-sponsored medical training, may be released at the conclusion of their two year tour of duty. We are hopeful that a sufficient number of doctors among those who have not served on active duty with the armed forces will volunteer so that a doctor draft can be avoided and no medical officers who have completed their tour of active duty will be retained."

From the Office of the Secretary of Defense comes word that by the end of July there will be a shortage of 1,600 physicians and 1,160 dentists. By next December this shortage will grow to 2,200

physicians and 1,400 dentists. In other words, there will not be enough professional men to give minimum service to nearly 1,700,000 men and women who are serving their country. Cooperation is asked in averting a situation that could have serious effects on the security of this country, and it is made clear that the armed forces are not asking for physicians and dentists from areas where a shortage already exists.

It is announced that this professional manpower shortage is so serious that legislation for a physician and dentist draft has been prepared and is being held for possible use. The Armed Forces Medical Advisory Committee, currently conducting an active campaign for medical and dental personnel, gives assurance that it will make an intensive study of the proper utilization of physicians and dentists, and of the workload in the armed forces, to insure against waste of precious professional manpower, and that, in so far as possible, men will receive assignments commensurate with their professional skills and abilities.

Does the medical profession want a doctor draft? We think not. The success of this procurement campaign will depend primarily upon public understanding and public support. Let the members of the Association do their part in translating the needs of the medical departments of the armed forces to the public and assist by making direct contact with individual physicians and dentists whom they know are affected by this appeal.

Postgraduate Medical Course on Cardiovascular Diseases June 14-17

The Department of Medicine of the Graduate School of the University of Florida announces a Special Course on Cardiovascular Diseases, which will be presented from June 14 through June 17 at the George Washington Hotel in Jacksonville. The recognition and management of heart conditions of particular interest to physicians in general practice will be featured. Dr. R. Bruce Logue of Emory University School of Medicine is the distinguished cardiologist who will present the lectures.

Committee of Forty Physicians Meets

A conference initiating the State Education Campaign of the Florida Medical Association was held at the George Washington Hotel in Jacksonville on Sunday, March 13, 1949 at 10 a.m., with Dr. Joseph S. Stewart, President of the Association, presiding. At that time the Committee of Forty Physicians met with the secretaries and chairmen of public relations committees of the component county medical societies and representatives of the Woman's Auxiliary. On the Committee each county medical society was officially represented by its president or a substitute appointed by him.

Dr. Stewart, State Campaign Chairman, heads the State Coordinating Committee, which directs this movement and sponsored the meeting. Serving with him are Dr. Walter C. Payne, President-elect, of Pensacola, and Dr. Homer L. Pearson, Jr., of Miami, who represents the Association in the House of Delegates of the American Medical Association.

The purpose of the meeting was twofold: (1) to launch a campaign of education on the local level, and (2) to study the plans of the national and state education campaigns, to discuss methods and procedures of expanding and implementing these programs in the respective communities, and to consider organizational procedures essential to effective action.

Dr. Stewart opened the meeting with a report of the meeting of the National Committee of Fifty-Three Physicians, held at the headquarters of the American Medical Association in Chicago on February 12. He stated that he was greatly pleased with Whitaker and Baxter, the public relations firm engaged to direct the American Medical Association Educational Campaign. He outlined the short range plan as one for immediate action (1) to see that every person learns something about compulsory health insurance, and (2) to encourage people to write to their representatives in the Congress and to President Truman. He referred to the Kiplinger Washington Letter of recent date which indicated that the volume of incoming mail from people in general is a sign that they are being stirred up. On the Michigan Group Plan, one of the better plans, $200,000 will be expended this year, he said.

Dr. Payne then addressed the assembly on "The Effectiveness of a 'Grass Roots' Campaign."

In a forthright manner he stated that those physicians who have been practicing medicine for more than twenty-five years have watched with concern the deterioration of the prestige of the physician in his community and have viewed with alarm the impending disaster embodied in the threat of socialized medicine. In his clear analysis of the situation he pointed out that this change has come about and this threat has arisen partly through the fault of the physicians. Too, specialization, increased costs of medicines and shortage of doctors have given momentum to the trend. Within recent years there has also been a popular movement to smear doctors, who as a group have been slow to recognize their changing position.

The attitude of the leaders of the American Medical Association has through the years been one of opposition to socialized medicine, but also one of apparent satisfaction with present conditions. Accordingly, until recently, no aggressive plan of positive action has been presented. Dr. Payne stated that he now is more encouraged over the position of the medical profession than he has been for a long while. He directed attention to the fact that the campaign is beginning somewhat late, but not too late. He paid tribute to a few men in the Association who several years ago had foresight enough to establish a voluntary plan of health insurance. Dr. Payne closed his impressive remarks by reminding the group that there has never been a time when physicians have needed more to conduct themselves so that credit and respect will be reflected upon the profession.

Mr. A. LeRoy Johnson, insurance executive and guest lay speaker, was introduced by Mr. Ernest R. Gibson, Public Relations Supervisor. Mr. Johnson stated that he had been requested to speak on the subject, "A Layman Looks at Socialized Medicine," but since he had never looked at socialized medicine firsthand, and hoped that he never would, he would change his subject somewhat and give reasons why a layman should fear socialized medicine. He mentioned first the confusion in the administration of medicine which would undoubtedly occur under direction by the federal government and pointed to specific instances of a ridiculous nature which occurred during his tour of duty in World War I. He stated that he had a vivid picture in his mind of the long lines of people waiting to receive rations during World War II and he thought it would be well to remind the people of that picture. He was of the opinion that the medical profession should change its phraseology to present in the minds of the people a picture that would better characterize compulsory health insurance. He suggested use of the term "government-rationed medical care," and he made it clear why it has been in the past and why it would be in the future the poor people who would suffer under such a system.

Mr. Johnson spoke of the importance of the intimate relationship between the physician and the patient and of the necessity for having time to give counsel; he then pointed out how much time was sure to be consumed under government control by extensive paper work. He urged that physicians approach the problem quietly, objectively and in a spirit of compromise and he remarked that name-calling does not help, reminding the group that the threat of socialized medicine is a healthful thing in that it will stimulate physicians to clean their own house and bring about needed improvements. He thought it wiser to admit frankly that certain features of the present mode of practice do need correction and cited as an example the fact that people in outlying sections do not receive adequate care.

Stating that in his experience legislators by and large want to do the right thing, Mr. Johnson suggested that physicians make the proper appeal to them. He also suggested that in the campaign they lay particular stress upon the appeal to members of the lower income group and that they appeal to women in particular, who are intensely interested in the health of their children.

Dr. Pearson then made a report on the meeting of the House of Delegates of the American Medical Association, held in St. Louis in December. Speaking on "The Necessity for the A. M. A. $25 Assessment," he pointed out that the $25 assessment levied on each member of the American Medical Association was made because the money was needed, that a big program has been outlined and that of approximately 150,000 members of the American Medical Association only about one half are fellows who bear the brunt of the general expenses. Hence, further assessment was necessary. Dr. Pearson in his inimitable manner told two amusing stories which illustrated well his points. Mr. Gibson reviewed a series of charts which gave in well summarized manner the issues at stake, the plan of attack, and a method of carrying out that plan. Special emphasis was laid upon the "Recommendations to County Medical Societies" for furthering the plan. These recommendations follow:

1. Meeting of the society—AT ONCE.
2. Report to members on Committee of 40 meeting.
3. Pass resolution opposing compulsory sickness insurance.
4. Select an active county society campaign chairman.
5. Select committee on education—10 per cent of membership.
6. Assign each committee member 10 doctors to inform.
7. Require each society member to contact 20 laymen.
8. Plan follow-up meetings.
9. Contact Senators and Congressmen by personal physicians.
10. Keep in constant liaison with state association.
11. Use Woman's Auxiliary—or special committee of doctors' wives.
12. Activate a press committee.
13. Have compiled a list of important local organizations.
14. Plan for visit by the representative.

Between the addresses of the speakers Dr. Stewart, in his usual impressive manner, made appropriate remarks which gave the meeting cohesiveness. He emphasized that there now is a positive plan of action which is to be a factual campaign versus propaganda, and presented the American Medical Association 12-Point Program.

Mr. H. A. Schroder, Executive Director of the Blue Shield and Secretary of the Blue Cross, addressed the group on the Blue Cross-Blue Shield organizations and traced the development of the Florida Medical Service organization from the time of its founding in 1946.

The meeting was then opened for general discussion from the floor. Several members participated, giving their personal reactions and general suggestions. Time was called out for luncheon, and then general discussion was resumed. Throughout, the conference was impressive and constructive. It is expected that it will be followed by positive action from the county medical societies.

Have you paid your A. M. A. assessment of $25.00 through the secretary of your county medical society?

Seminar on Tuberculosis
May 11-13

A Seminar on Tuberculosis will be held at the State Tuberculosis Sanatorium in Orlando on May 11, 12 and 13. This is one of a series of postgraduate medical courses presented by the Department of Medicine of the Graduate School of the University of Florida in cooperation with the Florida Medical Association and the Florida State Board of Health. A short, intensive program covering case findings, early diagnosis, differential diagnosis, treatment and postsanatorium follow-up has been arranged, as follows:

Case Findings—Early Diagnosis Differential Diagnosis

Wednesday, May 11

9:30 a.m. "Case Findings by the Nurse and Social Worker," Mrs. Ramona Masure
10:20 a.m. Recess
10:30 a.m. "Case Findings and Diagnosis," (with 70mm. film), Dr. C. M. Sharp
11:20 a.m. Recess
11:30 a.m. "Use of the 14x17 Chest Film as a Routine Hospital Procedure," Dr. J. A. Beals
12:30 p.m. Luncheon
2:00 p.m. "Early Diagnosis from the Clinical Standpoint," Dr. Phillip W. Horn
2:50 p.m. Recess
3:00 p.m. "Laboratory Diagnosis," Dr. A. V. Hardy, State Board of Health
3:50 p.m. Recess
4:00 p.m. "Differential Diagnosis," Dr. Isaac B. Cippes

Phases of Treatment

Thursday, May 12

9:30 a.m. "Chemotherapy," Dr. Roger J. B. Hibbard
10:30 a.m. "Pneumothorax," Dr. Lawrence C. Manni
11:05 a.m. Recess
11:15 a.m. "Pneumoperitoneum," Dr. John A. Kelk
11:50 a.m. "Phrenic Nerve Block," Dr. L. H. Kingsbury
12:25 p.m. Luncheon
2:00 p.m. "Extrapleural Collapse," Dr. W. O. Fowler
2:50 p.m. Recess
3:00 p.m. "Thoracoplasty," Dr. L. H. Kingsbury
3:50 p.m. Recess
4:00 p.m. "Lobectomy and Pneumonectomy," Dr. W. O. Fowler

Follow-Up

Friday, May 13

9:00 a.m. "Follow-Up from the Sanatorium Viewpoint," Dr. C. M. Sharp
10:00 a.m. "Follow-Up from the Private Physician's Viewpoint," Dr. M. Jay Flipse
10:30 a.m. "Rehabilitation of the Tuberculous Patient," Dr. Claud M. Andrews, State Department of Vocational Rehabilitation
11:00 a.m. "Panel Discussion of Follow-Up," Moderator: Dr. C. E. Aucremann

Panel Members:

Dr. C. M. Sharp, Chief Medical Director, State Tuberculosis Board, representing the Sanatorium
Dr. M. Jay Flipse, representing the Private Physician
Dr. W. L. Wright, representing the Health Officer
Mrs. Wm. Stack, representing the Tuberculosis Secretary
Mrs. Anna Lovell, representing the Social Worker
Mr. Wm. J. Miller, representing the Rehabilitation Counselor

The Seventeenth Annual Graduate Short Course

This year the Graduate Short Course will be held June 20-25 at the George Washington Hotel in Jacksonville. The detailed program for this seventeenth annual presentation will be announced well in advance and will be published in the June Journal.

A distinguished faculty will lecture on medicine, surgery, pediatrics, obstetrics, gynecology and psychiatry. The medical teachers who will present the courses are: Dr. Thomas M. Durant, Professor of Clinical Medicine, Temple University School of Medicine, Philadelphia, Pa.; Dr. Keith S. Grimson, Associate Professor of Surgery, Duke University, Durham, N. C.; Dr. James G. Hughes, Associate Professor of Pediatrics, University of Tennessee School of Medicine, Memphis, Tenn.; Dr. Frank R. Lock, Professor of Obstetrics and Gynecology, Wake Forest College, The Bowman Gray School of Medicine, Winston-Salem, N. C.; Dr. John B. Cross, Department of Obstetrics and Gynecology, Emory University, Emory, Ga.; and Dr. Harlan Crank, The Menninger Foundation, Topeka, Kan.

American Academy of Neurology

Announcement is made of the establishment of the American Academy of Neurology, whose purpose it is to further and encourage the practice of clinical neurology and to stimulate teaching and research in neurology and allied sciences.

Active Membership in the Academy is open to every physician who has been certified in neurology or in both neurology and psychiatry. Junior Membership is available to physicians presently engaged in postgraduate studies in neurology or who are awaiting certification in neurology. In addition, there is an Associate Membership for those who are not certified in neurology but whose interests are in fields related to neurology. It is hoped that, because of the unrestricted membership, this association will be representative of the entire neurologic specialty and will offer an organ of expression for many of the younger men in the field. At present, the American Academy of Neurology has 500 members.

The first business meeting was held in Chicago in June 1948. The first scientific meeting will be held at the French Lick Springs Hotel, French Lick Springs, Ind., on Wednesday, Thursday and Friday, June 1, 2 and 3, 1949. Dr. Dave B. Ruskin of the Caro State Hospital, Caro, Mich., is in charge of the scientific program. Communications to the Academy should be addressed to Dr. Joe R. Brown, 19 Millard Hall, University of Minnesota, Minneapolis 14, Minn., who serves as secretary-treasurer. Dr. A. B. Baker, also of the University of Minnesota, is this new organization's first president.

American Board of Preventive Medicine and Public Health, Incorporated

The newly created American Board of Preventive Medicine and Public Health, Incorporated, received in February the approval of the Advisory Board for Medical Specialties and the Council on Medical Education and Hospitals of the American Medical Association. It is therefore prepared to accept applications for examination for certification in this specialty.

The requirements for certification include general qualifications, such as moral and ethical standing in the profession, adequate training in medicine and internship in an approved hospital, and licensure to practice medicine in the United States. Eligibility for examination also requires that the applicant have special training and experience in preventive medicine and public health of at least six years following internship. This must include special academic training, or its equivalent, and field training or residency meeting the standards set up by the Board.

A Founders Group, exempt from examination, has been authorized, and applications for this group may now be received. It is to be made up of practitioners of preventive medicine and public health who have attained unquestioned eminence in the field. Presumably the Founders Group will include persons having attained eminence as indicated by academic appointments at the level of professor or associate professor of preventive medicine and public health, or who have held positions of eminence and responsibility for a period of not less than ten years in this field.

YOUR BLUE SHIELD

. . . Lest We Lose by Default

What is the significance of the word "voluntary?" We have used it so often that it is in danger of becoming a stereotyped label instead of a living word filled with energy and promise. The dictionary defines "voluntary" as "acting of one's free will, choice or accord; spontaneous; free; not compelled by another; unrestrained by any external influence, force, or interference."

The merits of voluntary action in providing health care have been established over the years in the development of voluntary hospital, medical and surgical care plans and in the progress of our medical sciences. More than 1,500 physicians in this State are meeting the needs of the public and preserving the traditions and character of their profession through participation in the Florida Blue Shield Plan, the "doctors' plan" that helps protect people of moderate income against unpredictable medical costs. The development of a voluntary method for bringing medical care within the financial reach of the public is evidence that the doctors are not "sitting back to see what happens."

Voluntary Blue Shield Plans throughout the country are being made successful by the active endorsement and participation of progressive doctors in the areas served. Their success and strength will increase with the growing cooperation of the medical profession.

What are the demonstrated merits of the voluntary system? Why does it deserve the support of a medical profession eager to preserve the traditions of private initiative and free enterprise? What is its appeal to the public?

The greatest merit of the voluntary medical plans is the fact that they provide a practicable solution to the problem without altering established patient-physician relationships. The voluntary system does not attempt to redesign the fabric of American medicine. Its objective is to make existing facilities available to a greater number of people at a cost all can pay.

Members have free choice of doctors, and the payments made for services rendered are based upon a realistic schedule. The Florida Medical Association has approved the agreement between Blue Shield and the Participating Physicians who have thereby demonstrated their willingness to offer the low income patient protection for which he would otherwise not be able to make payment. Because the plan functions on a community level, there is a maximum of direct contact with the doctor and a minimum of red tape.

From the patient's point of view, voluntary prepayment plans offer an opportunity for protection against health costs that does not involve loss of self respect or independence. The very fact that the patient has gained this protection by his own choice and is paying for it without compulsion adds to his self respect and feeling of adequacy.

The voluntary method, by its definition, is the logical method to receive the encouragement of those who wish to practice "unrestrained by any external influence, force or interference." That encouragement may be given by becoming a Participating Physician and by bringing the benefits of the plan to the attention of patients.

Any licensed physician may become a participant in the Florida Blue Shield Plan. All physicians should become familiar with its objectives and provisions so that they may discuss it with their patients and friends.

We all know and value the merits of the voluntary system. Both doctors and patients will enjoy its growing advantages in the future unless, by taking it for granted, we lose it by default.

STATE BOARD OF HEALTH

Creeping Eruption Survey

On Oct. 4, 1948, the State Board of Health mailed a questionnaire to 1,100 physicians concerning creeping eruption. Each physician was asked how many cases of creeping eruption he had treated during the past six months and for his comments. Through Nov. 30, 514 physicians replied to this questionnaire and stated that they had treated 7,781 cases of creeping eruption during the six months' period. This response proves conclusively that this condition is far more prevalent than anyone had realized.

With regard to treatment methods, the vast majority of the physicians stated they obtained favorable results with some type of freezing, either by using ethyl chloride spray or by employing dry ice. Others stated that results with these two agents were not too good. Some stated they obtained good results by employing some type of freezing in conjunction with intramuscular injec-

tions of fuadin. Some claimed favorable response to onion poultices. Some prefer treatment with tincture of iodine and carbolic acid, neutralized with alcohol, and then the application of ethyl chloride spray.

Many of the physicians commented that the disease was even more prevalent than indicated by the number of cases revealed by the survey, and that many patients never reach the physician's office, but buy the ethyl chloride spray at drug stores and treat themselves.

The survey indicates that physicians would welcome a better method of treating this distressing condition. Many inquiries were made as to how this condition could be better controlled, as by decontamination of the soil, control of animals, et cetera.

In the future some attempt will be made to study this problem further with the view in mind of working out better methods of control. This seems to be a condition which is well worthwhile to study. Anyone discovering a better method of treating this annoying condition would be performing a real public service.

Action Taken in Medical Practice Act Cases

In a summary of its activities from 1941 through 1948, the Bureau of Narcotics of the Florida State Board of Health, under the direction of Mr. M. H. Doss, makes the following report:

Number criminal cases resulting in an arrest	88
Aggregate sentences imposed by the courts	47 years, 4 months, 8 days
Aggregate fines imposed by the courts	$7,833.08
Number criminal cases pending in courts	22
Number prosecutions resulting in mistrial	2
Number defendants receiving suspended sentences	16
Number violations corrected where no legal action was taken	193
Number defendants placed on probation	5
Number defendants enjoined by courts	4
Number cases passed to absentee docket	1
Aggregate bonds estreated	$200.00
Number cases resulting in an acquittal	3
Number cases discharged or nolle prosequi by the courts	2

Its record of having only five cases of eighty-eight arrests result in mistrial or acquittal is to be highly commended. This bureau of the State Board of Health is performing an outstanding service not only to the public, but also to the medical profession in the state.

New Cancer Film

First in a new series of diagnostic films in color, "Cancer: the Problem of Early Diagnosis," is designed to show that the family physician offers the only immediate hope of reducing the annual toll of more than 180,000 deaths from cancer. The film portrays graphically the difference made today by early diagnosis of cancer of the stomach, breast, rectum, cervix and lung.

This film is suitable for hospital staffs, medical societies, and any gathering of physicians or nurses.

It is a 16 mm. sound film in color, with a running time of thirty minutes.

You can get this film for a single showing from the Florida State Board of Health.

Every medical society should schedule this film for one of its medical meetings, and every physician should make it a point to see this excellent film.

Dr. Albert V. Hardy, director of the Bureau of Laboratories of the State Board of Health, has been appointed a member of the Enteric Fever Commission of the Army Epidemiological Board. There are only four members of this Commission and they are appointed as Medical Consultants to the Secretary of War. Dr. Hardy is considered to be an outstanding authority on the enteric diseases.

BIRTHS, MARRIAGES AND DEATHS

Births

Dr. and Mrs. E. Frank McCall, Jacksonville, announce the birth of a daughter, Sara, on March 4, 1949.

Dr. and Mrs. Millard P. Quillian, Bradenton, announce the birth of a son, Millard Bernard, on March 5, 1949.

Dr. and Mrs. Thomas Z. Stanley, Jacksonville Beach, announce the birth of a daughter in February, 1949.

Dr. and Mrs. William J. Phelan, Jacksonville, announce the birth of a son, Timothy Michael, on March 21, 1949.

Marriages

Dr. H. Phillip Hampton of Tampa and Miss Katherine Hughes Barker were married on March 19, 1949.

Deaths — Members

Dr. Roland T. White, Orlando	March 5, 1949
Dr. George L. Cook, Tampa	March 8, 1949
Dr. Hobart E. Warren, Palm Beach	March 17, 1949

Deaths—Other Doctors

Dr. Walter Weller, Gainesville	March 11, 1949
Dr. H. B. Fisk, Miami	Feb. 11, 1949
Dr. Percy J. Delano, Chicago	Jan. 13, 1949

WANTED: Florida location for permanent practice by class A graduate, well trained and experienced. Have license and available at once. American; age 49. Address Doctor, Box 306, Mississippi City, Miss.

STATE NEWS ITEMS

Dr. C. Frank Chunn of Tampa was the guest speaker at the Cancer Seminar of the State of Mississippi which was held on March 11. Dr. Chunn presented a paper on the diagnosis and treatment of "Carcinoma of the Esophagus."

The Seventeenth Annual Assembly of The Southeastern Surgical Congress will be held at The Buena Vista Hotel in Biloxi, Miss., from May 23 through May 26. Forty-three papers will be presented by distinguished surgeons from the South and throughout the country.

Dr. Robert E. Zellner of Orlando was the guest speaker at the March 15 meeting of the local Rotary Club. His subject was "Socialized Medicine." Dr. Clinton H. Whitehurst of Winter Garden was in charge of the program.

Dr. Alan Brown, formerly of Jacksonville, has opened offices at 902 South Ft. Harrison Avenue, Clearwater.

The Cook County Graduate School of Medicine of Chicago has arranged two courses that will be of special interest to some members of the Association. A two weeks' intensive personal course in the "Diagnosis and Treatment of Congenital Malformations of the Heart" will be offered by Dr. Benjamin M. Gasul, starting Monday, June 13. A two weeks' intensive personal course in "Cerebral Palsy" will be offered by Dr. M. A. Perlstein, starting Monday, August 1. These physicians are members of the Attending Staff of the Cook County Hospital.

Dr. Millard P. Quillian of Bradenton addressed members of the Palmetto Rotary Club on March 15. Dr. Quillian discussed the socialization of medicine.

Eight members of the Florida Medical Association were registered at the meeting of the American Academy of General Practice which was held in Cincinnati in early March. They are Dr. T. D. Sandberg of Coral Gables, Dr. Gustave T. Eith of Daytona Beach, Dr. Walter E. Murphree of Gainesville, Drs. Norris M. Beasley and Richard A. Mills of Ft. Lauderdale, Drs. Raymond R. Killinger and Elmer E. Leitner of Jacksonville, and Dr. Walter B. Johnston of Winter Park.

Dr. Adolph B. Cone of Jacksonville Beach was a guest speaker at the February 18 meeting of the local Junior Woman's Club.

Dr. Walton B. Wall, Jr., of Orlando spoke on "Socialized Medicine" before members of District 8, Florida State Nurses' Association on February 22.

Dr. J. Maxey Dell, Jr., of Gainesville, chairman of the public relations committee of the Alachua County Medical Society, spoke to the Jacksonville Beaches' Kiwanis Club on February 24. His subject was "National Compulsory Health Insurance."

The Sixty-First Annual Meeting of the American Association of Railway Surgeons will be held at the Drake Hotel in Chicago on Thursday, June 30, Friday, July 1, and Saturday morning, July 2. For additional information, address the secretary, 5800 Stony Island Avenue, Chicago.

Dr. Cornelia M. Carithers of Jacksonville spoke on "The Status of the Woman Doctor" at the March 16 meeting of the Woman's Club of Jacksonville.

Dr. Irving J. Strumpf of Jacksonville vehemently denounced the proposed national health insurance at a luncheon meeting of the Jacksonville Southside Business Men's Club on March 16. Dr. Strumpf is chairman of the club's public health committee.

Dr. James T. Cook of Marianna has resumed his professional duties after completing a ten-day postgraduate course in New Orleans.

Dr. James B. Parramore of Key West has announced his resignation as director of the Monroe County Health Unit because of ill health. He has been director for the unit for twelve years.

WANTED: Practicing physician; Florida license not required. For further information write Clinical Director, Florida State Hospital, Box 189, Arcadia, Fla.

FOR SALE: General practice, including equipment. Central downtown location in beautiful Sunshine City of St. Petersburg, Fla.; population, 100,000. Price, $5,000; easy terms. Leaving June 15 to accept residency. Will introduce. Write P. O. Box 658, Station A, St. Petersburg, Fla.

NEW MEMBERS

The following doctors have joined the State Association through their respective county medical societies.

Bluestone, Alexander H., Hollywood
Bowen, Jack H., Jacksonville
Burns, Joseph, Miami Beach
Clark, George B., Bradenton
Daughtrey, John E., Lakeland
Garrett, Thomas C., Sarasota
Granade, John E., Bradenton
Greenberg, Philip M., Miami Beach
Head, Robert G., Marianna
Honigsberg, Alvin, Miami Beach
Keith, Walter P., Jacksonville
McCloskey, Bernard J., Jacksonville
Meister, A. George, Sarasota
Mentzer, Dodge D., Lakeland
Rezek, Phillipp R., Miami
Rolls, Karl R., Sarasota
Schneider, Irvin C., Jacksonville
Smith, Marshall E., Tampa
Taylor, J. Champneys, Jacksonville
Trice, William W., Jr., Tampa

COMPONENT SOCIETY NOTES

DeSoto-Hardee-Highlands-Charlotte-Glades

The regular meeting of the DeSoto-Hardee-Highlands-Charlotte-Glades County Medical Society was held on March 8 at Aqua Vitae Springs. Dr. William C. Blake of Tampa, the guest speaker, presented a paper entitled, "Important Clues in Cardiovascular Diagnosis."

Other guests present included Dr. Leland F. Carlton of Tampa, Drs. R. N. and T. N. Rafferty of Sebring, and Dr. J. Paul Chapin of Avon Park.

Members attending the meeting were Drs. Harold S. Agnew, Roland W. Banks, Godfrey L. Beaumont, Henry P. Bevis, Isaac W. Chandler, Hubert W. Coleman, George F. Highsmith, Merle C. Kayton, Charles H. Kirkpatrick, Gordon H. McSwain, Leldon W. Martin, Edwin C. Northup, Harold E. Parker, Wesley S. Pyatt, Zaven M. Seron, John A. Simmons, Stanley K. Wallace and Howard V. Weems.

Escambia

Members of the Escambia County Medical Society were guests of Capt. W. H. Davis, United States Navy, at the Naval Hospital in Pensacola on March 8. Following dinner, Dr. Wilmot Littlejohn, professor of Neuropsychiatry, University of Alabama, presented a paper entitled, "Convulsive Disorders of the Epileptic Type."

Hillsborough

Dr. George L. Apfelbach, assistant professor of Bone and Joint Surgery at Northwestern University, Chicago, and chairman of the Female Fracture Service of the Cook County Hospital, addressed members of the Hillsborough County Medical Association on March 1. Dr. Apfelbach spoke on "Solved and Unsolved Problems of Fractures of the Neck of the Femur."

Marion

At the regular monthly meeting of the Marion County Medical Society held at the "1890 House" in Ocala on March 16, Dr. Robert E. Thompson, president, reported on the recent meeting of the state Committee of Forty, representatives of the component county medical societies. The meeting, which was held at the George Washington Hotel in Jacksonville on March 13, was called by Campaign Chairman Joseph S. Stewart of Miami.

Major Holbrook Scott of Ocala, a publicity agent, addressed members on the history and various aspects of socialized medicine and compulsory health insurance, specifically in Sweden, where he saw the plan in operation last summer.

The society passed the following motions: (1) That the Marion County Medical Society help in opposing socialized medicine and back up the program of the state Committee of Forty; (2) That Dr. Richard C. Cumming, the society's public relations officer, and his committee be empowered to act.

The following members attended the meeting: Drs. Cumming, T. Hartley Davis, Bertrand F. Drake, William H. Garvin, Jr., Henry L. Harrell, Eaton G. Lindner, Carl S. Lytle, William J. McGovern, John N. Moore, Robbins Nettles, Eugene G. Peek, Jr., Ralph E. Russell, Robert E. Thompson, Thos. H. Wallis and Harry F. Watt. Dr. John P. Moore, a former member of the society, has finished specialized courses and work in roentgenology and radiology in Washington, D. C., and has returned to practice with his father, Dr. John N. Moore.

Monroe

All members of the Monroe County Medical Society have paid 1949 State Association dues.

Pinellas

The Pinellas County Medical Society held its regular monthly Picomeso Hour, Dinner and Meeting at the Detroit Hotel, St. Petersburg, on March 7. Dr. Francis H. Langley presided.

Following the business meeting, Dr. Albert R. Frederick introduced Dr. George F. Hieber who opened a symposium on the "Use of the Radium Applicator in the Treatment of Asthma in Children." Dr. Miller O. McNay presented the otolaryngologist's opinion and Dr. Councill C. Rudolph discussed the subject from the pediatric viewpoint. Dr. Arnold S. Anderson also spoke.

Dr. Frederick then introduced Dr. Gideon Timberlake who spoke on "Prostate in Health and Disease." Dr. Timberlake's lecture was discussed by a guest urologist.

Polk

Dr. Lowell S. Selling of Orlando was the guest speaker at the March meeting of the Polk County Medical Society. His enlightening paper was entitled "Modern Psychiatry."

Short, interesting talks were given by Mr. Loyall Frisbie of Bartow, chairman of the Board of Trustees of the Children's Guidance Center, and by Judge Hunt of the Polk County Juvenile Court, relative to the work in the Child Guidance Center.

OBITUARIES

William John Buck

Dr. William J. Buck of Belle Glade died suddenly on Jan. 13, 1949 after suffering a heart attack in his parked automobile in the yard of his home. He was 60 years of age.

Dr. Buck was born in Iowa in 1888. He received his medical education at Hering Medical College in Chicago, from which he was graduated in 1912. During the first World War, he served as a colonel in the United States Army Medical Corps. He received the personal commendation of General Pershing for his excellent administration of the 2,000 bed hospital which he commanded at Lemons, France.

This prominent Glades physician began his Florida career in Jacksonville. In 1928, after spending several years in West Palm Beach with the State Department of Health, he opened offices in Belle Glade.

A pioneer of the little town, Dr. Buck was one of its leading citizens. His willingness to accept responsibility and his ability as an executive and an administrator are engraved in the town's growth. When Belle Glade was the victim of a hurricane in the spring of 1928, Dr. Buck assumed the leadership in rescue work; he was cited by the United States Government for his continuous duty for five or six days during the disaster. The local American Legion post, newly organized and commanded by him, helped meet the demands of the crisis under his direction. He was the first chairman of the Community Red Cross Committee which further aided the destitute community.

Other outstanding services included membership on the first Town Council, leadership in organizing the local Rotary Club, efforts in behalf of the physical improvement of the town, and organization of the first Community Sunday School. This able public servant was a member of the Episcopal Church.

Dr. Buck was a past president of the Rotary Club; a past district commander of the Vero Beach-Key West area of the American Legion, as well as chairman of several state committees; and a member of the 40 and 8, the Elks' Club, the Masonic Order and the Shrine.

At the time of his death, Dr. Buck was chief of staff of the Belle Glade Hospital and chairman of the board of the Western Palm Beach County Hospital Association. He had served as chief of staff of the Pahokee Hospital. He was a member of the Palm Beach County Medical Society, the Florida Medical Association and the American Medical Association.

Surviving are his wife, Mrs. Sue Florence Buck; a daughter, Mrs. Mary Parrish of Gainesville; and a son, Sgt. William C. Buck, stationed with the United States Army Air Corps Ground Forces in San Angelo, Tex.

George Lindsay Cook

Dr. George L. Cook of Tampa died on March 8, 1949 at the Tampa Municipal Hospital after a brief illness. Death was attributed to a heart ailment. He was 62 years of age.

Dr. Cook was born on Oct. 10, 1886 in Waynesboro, Va. He received his medical education at the University College of Medicine in Rich-

mond, Va., from which he was graduated in 1913. He served three years as an intern in New York hospitals before entering the United States Army Medical Corps during the first World War. After termination of military service in 1919, Dr. Cook practiced medicine in Atlanta until 1925, when he moved his offices to Tampa. He practiced in that city continuously until his death, specializing in orthopedic surgery.

This distinguished surgeon was a member of the American Board of Pediatrics, the American Academy of Pediatrics and the American College of Physicians, and was state chairman of the Florida Chapter of the American Academy of Pediatrics. He was a member of the Hillsborough County Medical Association, which he served as president in 1937. He had been a member of the Florida Medical Association since 1926. During that time he was a member of the Executive Committee for three years, a member of the Committee on Medical Postgraduate Course for eight years, chairman of the Committee on Child Health for four years, and associate editor of The Journal for three years. In 1937 he served as third vice president of the Association. He was a fellow of the American Medical Association.

Dr. Cook was prominent socially and in civic affairs. He was a member of the vestry of St. John's Episcopal Church.

Survivors include his widow, Mrs. Marion F. Cook, Tampa; a son, Fielder Cook, New York City; a daughter, Miss Mary Ellen Cook; three brothers, Fred Cook and Tucker Cook, Waynesboro, Va., and Henry E. Cook, Boise, Idaho; and a sister, Mrs. Mamie Hamilton, Waynesboro, Va.

Haynsworth Dowling Clark

Dr. Haynsworth D. Clark of Fort Pierce died after several weeks' illness on Jan. 15, 1949 in the Fort Pierce Memorial Hospital. He was 56 years of age.

A native Floridan, Dr. Clark was born on Sept. 9, 1892 in Alachua. After receiving his elementary education in the schools of Alachua County, he studied medicine at the University of Maryland School of Medicine and College of Physicians and Surgeons in Baltimore. He was graduated in 1914. Following an internship at the Robert Garrett Memorial Hospital in Baltimore, he opened his office for the practice of medicine in Fort Pierce in 1915. With him came his wife, the former Miss Travis Keene, daughter of Dr. and Mrs. H. E. Keene, to whom he was married in 1913.

Dr. Clark was one of Fort Pierce's pioneer family practitioners. He served as a medical examiner for the local draft boards in World War I and World War II, was city health officer for a number of years and was a surgeon for the Florida East Coast Railway for many years. He filled the office of secretary to the Florida Railway Surgeons' Association for five years and became its president in 1939. He was a member of the Phi Rho Sigma medical fraternity.

His activities in medical circles were numerous. He served as president of the St. Lucie-Okeechobee-Indian River-Martin County Medical Society in 1937. During his many years of service to the Florida Medical Association he was a District Councilor from 1928 to 1932 and from 1937 to 1939. From 1940 to 1942 he served as a member of the Association's Committee on Necrology. He also was a member of the American Medical Association.

Dr. Clark was prominent in civic and fraternal activities. He was a member of the Elks' Lodge and various Masonic Orders and was a former Rotarian.

Surviving are his wife, Mrs. Travis Clark; two daughters, Mrs. F. Willes of Miami and Mrs. A. S. Aiken of Fort Pierce; a son, Haynsworth Keene Clark of Fort Pierce; a brother, Samuel R. Clark of Tampa; two sisters, Mrs. Paul Lainhardt of Tampa and Mrs. Walter Williams of Gainesville; and two grandchildren.

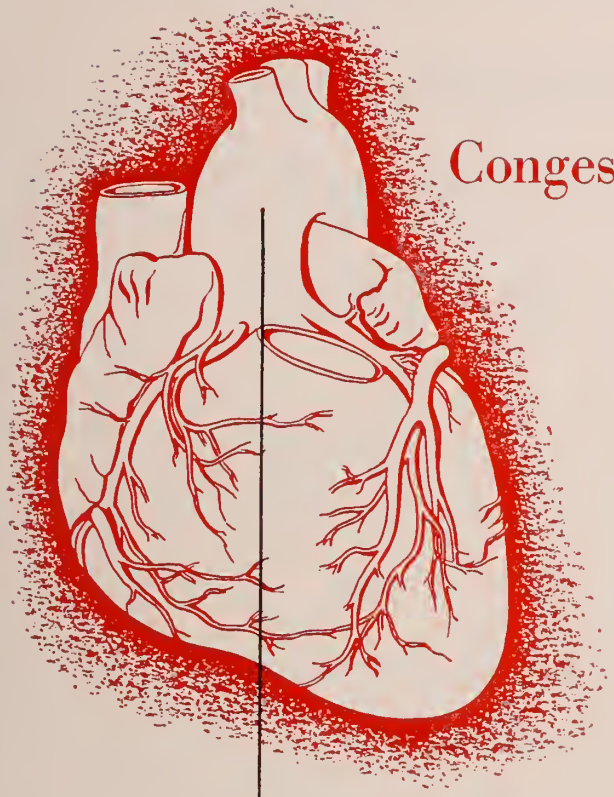
John Leslie Redding

Dr. John L. Redding of Orlando died on Sept. 29, 1948 in a local hospital. He was 72 years of age.

Dr. Redding received his medical education at the Medical College of Indiana, Indianapolis, from which he was graduated in 1904. During the first World War, he served in France with the United States Army Medical Corps. Dr. Redding had practiced medicine in Indiana until 1922, when he moved his offices to Orlando, where he practiced continuously until the time of his death.

He was affiliated with the Masonic Order, was a member of the Shrine, the American Legion, the

(Continued on page 725)



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1. Howarth, S.; McMichael, J., and Sharpey-Schafer, E. P.: The Circulatory Action of Theophylline Ethylene Diamine, Clin. Sc. 6:125 (July 17) 1947.

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Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154; Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60; Proc. Soc. Exp. Biol. and Med., 1934, 32-241; N. Y. State Journ. Med., Vol. 35, 6-1-25, No. 11, 590-592.

Veterans of Foreign Wars and the Woodmen of the World. He was a member of the Episcopal Church in Orlando.

Dr. Redding was a member of the Orange County Medical Society, the Florida Medical Association, and the American Medical Association.

Survivors include two sons, John Raymond Redding of Orlando, and Robert Louis Redding of Washington, D. C.; two brothers, Rufus Marion Redding of Freeport, Tex., and Linden Redding of Marion, Ind.; and two sisters, Mrs. Olive Crofut of Freeport, Tex., and Mrs. Cora Brown of Warren, Ind.

BOOKS RECEIVED

Psychodynamics and the Allergic Patient. By Harold A. Abramson, M.D. Price $2.50. Pp. 81. St. Paul, Minn.: Bruce Publishing Company, 1948.

An official publication of The American College of Allergists, this book represents the first step in the coordination of organizational allergy and psychodynamics. The object is to focus on the importance of emotional factors in the routine therapy of the allergic patient by both the allergist and the general practitioner.

The author's article on "Psychodynamics and the Allergic Patient" brings forth convincing evidence of the inadequacy of the histamine theory of allergy and the importance of emotional factors. There is also a chapter by the author on the psychosomatic aspects of hay fever and asthma prior to 1900. In addition, the book records the first panel discussion on the role of psychodynamics and the allergic patient, arranged by allergists under the auspices of The American College of Allergists at its Third Annual Meeting held in June 1947. By bringing together authorities in the field of psychiatry and authorities interested in the immunologic aspects of the problem involved in treating the allergic patient, it was possible to take this first step in the consideration of the coordination of the disciplines of applied immunology and of psychodynamics on the same program in a constructive way. All students of allergy and psychiatry will be stimulated by this free discussion of controversial questions.

Essentials of Gynecologic Endocrinology. By Gardner M. Riley, Ph.D. Price, $3.00. Pp. 205. Ann Arbor, Mich.: Caduceus Press, 1948.

This presentation of the fundamentals of reproductive physiology, the endocrine aspects of gynecologic dysfunction, and details of useful diagnostic procedures is designed as a source of endocrine information for medical students, interns, and those of the medical profession whose daily lot it is to deal with the vagaries of male or female gonadal function. The three sections of the book are designated as "Endocrine Physiology," "Clinical," and "Diagnostic Procedures, Sex Hormone Chemistry and Endocrine Preparations."

The author is Assistant Professor of Obstetrics and Gynecology, University of Michigan Medical School, and head of the Gynecological Endocrine Laboratory of the University Hospital in Ann Arbor.

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Joe Marsh

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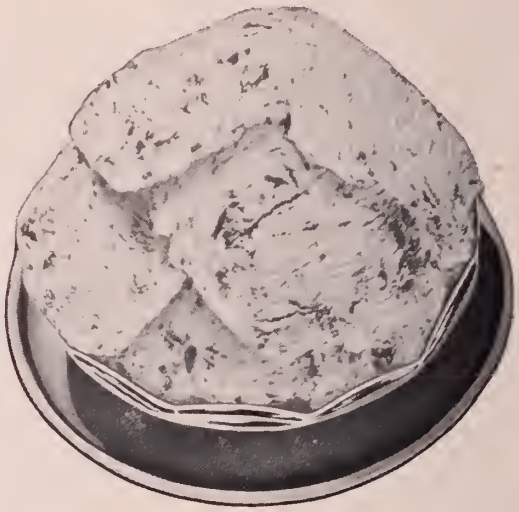
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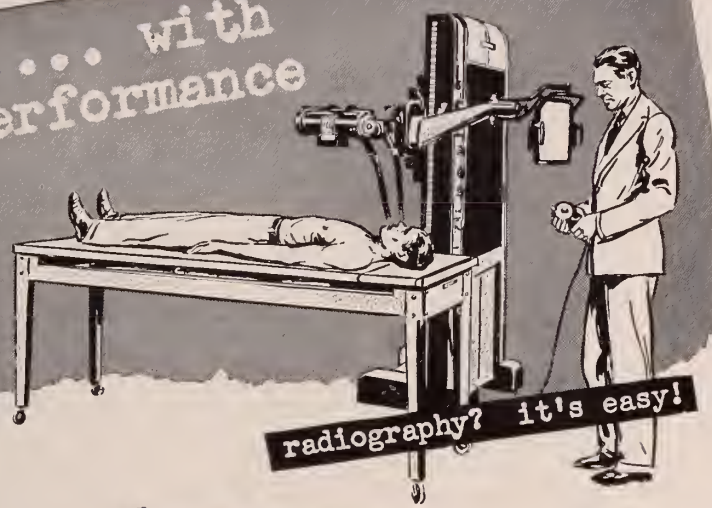


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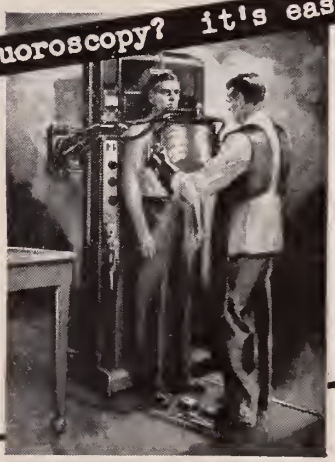
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SCHEDULE OF MEETINGS

ORGANIZATION	PRESIDENT	SECRETARY	ANNUAL MEETING
orida Medical Association	Walter C. Payne, Pensacola	Robert B. McIver, Jacksonville	Hollywood, Apr. 23-26, 1950
orida Medical Districts	Russell B. Carson, Ft. Lauderdale	Council Chairman	
A-Northwest	William P. Hixon, Pensacola	Taylor W. Griffin, Quincy	Quincy, 1949
B-Northeast	Charles C. Grace, St. Augustine	Cleland D. Cochrane, Daytona Beach	Palatka, 1949
C-Southwest	H. Quillian Jones, Ft. Myers	M. Crego Smith, Clearwater	Sebring, 1949
D-Southeast	Erasmus B. Hardee, Vero Beach	S. Marion Salley, Miami	Ft. Lauderdale, 1949
orida Specialty Societies			
Derm. and Syph., Soc. of	A. Buist Litterer, Miami	Wesley W. Wilson, Tampa	Hollywood, Apr. 23, 1950
Genl. Practice of Med.	M. Crego Smith, Clearwater	Walter E. Murphree, Gainesville	" "
Health Officers' Society	Roger F. Sondag, Jacksonville	Lorenzo L. Parks, Jacksonville	" "
Industrial & Railway Surgeons	F. Hardy Bowen, Jacksonville	J. H. Mitchell, Jacksonville	" "
Neurology & Psychiatry	James G. Lyerly, Jacksonville	William H. McCullagh, Jacksonville	" "
Ob. and Gynec. Society	Chas. J. Collins, Orlando	Dorothy D. Brame, Orlando	" "
Ophthal. & Otol., Soc. of	Bascom H. Palmer, Miami	W. Jerome Knauer, Jacksonville	" "
Orthopedic Society	Charles B. Mabry, Jacksonville	Eugene L. Jewett, Orlando	" "
Pathological Society	James N. Patterson, Tampa	Gretchen V. Squires, Pensacola	" "
Pediatric Association, State	Edgar W. Stephens, W. P. Beach	Hugh A. Carithers, Jacksonville	" "
Proctologic Society	Dean W. Hart, St. Petersburg	Frederick E. Farrer, Miami	" "
Radiological Society	James F. Pitman, Lake City	Floyd K. Hurt, Jacksonville	" "
Urological Society	Milton M. Coplan, Miami	Russell B. Carson, Ft. Lauderdale	" "
orida—			
Basic Science Exam. Board	Paul A. Vestal, Winter Park	M. W. Emmel, D.V.M., Gainesville	Gainesville, June 11, '49
Dental Society, State	T. C. Henslee, D.D.S., Miami	Larry Schulstad, D.D.S., Bradenton	
Hospital Association	Mr. H. Louie Wilson, Gainesville	Mr. H. A. Schroder, Jacksonville	November, 1949
Hospital Service Corporation	Mr W. E. Arnold, Jacksonville	Mr. H. A. Schroder, Jacksonville	Jacksonville, Feb. 14, '50
Medical Examining Board	Homer L. Pearson, Jr., Miami	Frank D. Gray, Orlando	Jacksonville, June 26-28, 1949
Medical Postgraduate Course	Turner Z. Cason, Jacksonville	Chairman	Jacksonville, June 20-25, '49
Medical Service Corporation	Leigh F. Robinson, Ft. Lauderdale	Herbert E. White, St. Augustine	
Nurses Association, State	Mrs. Elsie M. Airheart, Tampa	Miss Helen Shearston, Miami	Sarasota, October, '49
Pharmaceutical Association, State	Mr. D. M. Weaver, Miami	Mr. R. Q. Richards, Ft. Myers	Miami, May 17-19, '49
Public Health Association	Turner E. Cato, Miami	Mr. Fred B. Ragland, Jacksonville	West Palm Beach, Oct. 6-8, '49
Tuberculosis & Health Assn.	Judge Ernest E. Mason, Pensacola	Mr. Walton MacJordan, Orlando	
Woman's Auxiliary	Mrs. L. E. Parmley, Winter Haven	Mrs. C. R. Morgan, Jr., Miami	Hollywood, Apr. 24-26, '50
erican Medical Association	R. L. Sensenich, South Bend, Ind.	Geo. F. Lull, Chicago	Atlantic City, June 6-10, 1949
uthern Medical Association	Oscar B. Hunter, Washington, D. C.	C. P. Loranz, Birmingham	Cincinnati, Nov. 14-17, '49
abama Medical Association	J. Paul Jones, Camden, Ala.	Douglas L. Cannon, Montgomery	
orgia, Medical Assn. of	Edgar Hill Greene, Atlanta	Edgar D. Shanks, Atlanta	Savannah, Ga., May 10-13, '49
E. Hospital Conference	Mr. Burton M. Battle, New Orleans	Mr. R. F. Whitaker, Atlanta	
utheastern Allergy Assn.	Oscar Swineford, Charlottesville, Va.	Kath. B. MacInnis, Columbia, S. C	Columbia, S. C., 1950
utheastern, Am. Urological Assn.	James J. Ravenel, Charleston, S. C.	Russell B. Carson, Ft. Lauderdale	Edgewater Park, Miss., Feb. 1-5, '50
utheastern Surgical Congress	Gilbert Douglas, Birmingham, Ala.	B. T. Beasley, Atlanta	Biloxi, Miss., May 23-26, '49

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	Escambia *Santa Rosa	Alvyn W. White, M.D. 24 W. Chase St. Pensacola	Arthur J. Butt, Jr., M.D. 1101 N. Palafox St. Pensacola	2nd Tuesday 8:00 P.M.	61	54	
	Franklin-Gulf	Albert L. Ward, M.D. Port St. Joe	Donald H. Anderson, M.D. Port St. Joe	3rd Tuesday Odd Months	7	6	A-1-50 William P. Hixon, M.D. Pensacola
	Jackson *Calhoun	Daniel A. McKinnon, M.D. Marianna	Francis M. Watson, M.D. 120 Deering St. Marianna	3rd Thursday 7:30 P.M.	19	17	
	Walton-Okaloosa	Arthur G. Williams, Sr. Lakewood	Ralph B. Spires, M.D. DeFuniak Springs	3rd Thursday 8:00 P.M.	14	100%	
	Washington-Holmes	N. J. Dawkins, M.D. Vernon	B. W. Dalton, M.D. Chipley		5	100%	
B	Columbia *Baker-Hamilton	Robert B. Harkness, M.D. 525 E. Duval St. Lake City	Thomas H. Bates, M.D. 27 W. Madison St. Lake City	1st Monday 7:30 P.M.	16	100%	
	Leon-Gadsden-Liberty-Wakulla-Jefferson	Merritt R. Clements, M.D. 1232 N. Monroe Street Tallahassee	Edward C. Love, Jr., M.D. Masonic Temple Bldg. Quincy	Quarterly 7:30 P.M.	44	42	A-2-51 Taylor W. Griffin, M.D. Quincy
	Madison-Suwannee	A. Franklin Harrison, M.D. Madison	Irby H. Black, M.D. 918 W. Howard St. Live Oak		10	9	195
	Taylor *Dixie-Lafayette	Walter J. Baker, M.D. Foley	Ralph J. Greene, M.D. Perry	Last Friday 8:00 P.M.	4	3	
	Alachua *Bradford, Gilchrist Union	Alva T. Cobb, Jr., M.D. 505 W. University Ave. Gainesville	F. Emory Bell, M.D. Box 400 Gainesville	2nd Tuesday 8:00 P.M.	39	36	
	Duval *Clay	Raymond R. Killinger, M.D. 225 W. Ashley St. Jacksonville	Janet G. Leser, M.D. 1016 LaSalle St. Jacksonville	1st Tuesday 8:15 P.M.	244	200	
	Marion *Levy	Robert E. Thompson, M.D. Holder Bldg. Ocala	Bertrand F. Drake, M.D. Professional Bldg. Ocala	3rd Wednesday 12:30 P.M.	28	25	B-3-50 Charles C. Grace, M.D. St. Augustine
	Nassau	David G. Humphreys, M.D. Fernandina	John W. McClane, M.D. Fernandina	Last Friday 8:00 P.M.	9	100%	
	Putnam	Grover C. Collins, M.D. 502 Reid St. Palatka	Lawrence G. Hebel, M.D. 119 N. 4th St. Palatka	2nd Tuesday 6:00 P.M.	9	100%	
	St. Johns	Reddin Britt, M.D. Box 565 St. Augustine	S. Raymond Cafaro, M.D. Exchange Bank Bldg. St. Augustine	3rd Tuesday 8:30 P.M.	15	14	
C	Brevard	Charles E. Russell, M.D. 16 Magnolia St. Cocoa	Theodore J. Kaminski, M.D. Box 576 Melbourne	2nd Tuesday	14	100%	
	Lake *Sumter	Leroy H. Oetjen, M.D. Leesburg	William L. Musser, M.D. Mount Dora	1st Wednesday 7:30 P.M.	21	2	B-4-51 Cleland D. Cochrane, M.D. Daytona Beach
	Orange *Osceola	Robert P. Henderson, M.D. 544 N. Orange Ave. Orlando	Gerald W. Jones, M.D. American Bldg. Orlando	3rd Wednesday 8:00 P.M.	136	119	
	Seminole	Leonard I. Munson, M.D. Touchton Bldg. Sanford	Frank L. Quillman, M.D. Box 158 Sanford	2nd Tuesday 5:30 P.M.	11	100%	
	Volusia *Flagler	Joseph H. Rutter, M.D. Rt. 1, Box 303-A Daytona Beach	Robert L. Miller, M.D. 258½ S. Beach St. Daytona Beach	2nd Tuesday 7:30 P.M.	53	46	579
	Hillsborough	William M. Rowlett, M.D. Box 786 Tampa	Herschel G. Cole, M.D. 315 Wallace S. Bldg. Tampa	1st Tuesday 8:00 P.M.	150	146	
	Manatee	Willis W. Harris, M.D. First National Bank Bldg. Bradenton	Joseph A. Gibson, M.D. Palmetto	3rd Tuesday 7:00 P.M.	22	15	C-5-51 M. Crego Smith, M.D. Clearwater
	Pasco-Hernando-Citrus	Donald G. Bradshaw, M.D. Zephyrhills	W. Wardlaw Jones, M.D. Box 247 Dade City	2nd Thursday 7:00 P.M.	12	11	
	Pinellas	Francis H. Langley 190 18th Ave. St. Petersburg	Whitman C. McConnell, M.D. 313 First Federal Bldg. St. Petersburg	1st Monday 6:30 P.M.	161	158	
	Sarasota	Millard B. White, M.D. 151 S. Pineapple Ave. Sarasota	Talmadge S. Thompson, M.D. Box 224 Venice	2nd Tuesday 8:30 P.M.	26	23	
	DeSoto-Hardee-Highlands-Charlotte-Glades	John A. Simmons, M.D. Box 430 Arcadia	Charles H. Kirkpatrick, M.D. Box 389 Arcadia	2nd Tuesday 8:00 P.M.	29	28	C-6-50 H. Quillian Jones, M.D. Ft. Myers
	Lee *Collier, Hendry	Curtis R. House, M.D. 2 Darling Bldg. Ft. Myers	Joseph L. Selden, Jr., M.D. 416 Richards Bldg. Ft. Myers	3rd Monday 7:30 P.M.	23	20	
	Polk	Byron Y. Pennington, M.D. Lake Wales	John W. Vaughn, M.D. Box 475 Lakeland	2nd Wednesday 7:00 P.M.	77	67	500
D	Indian River	John P. Gifford, M.D. Vero Beach	William L. Fitts, 3rd, M.D. Vero Beach Arcade Vero Beach	2nd Tuesday 8:00 P.M.	8	100%	
	Palm Beach	William E. Bippus, M.D. Comeau Bldg. West Palm Beach	Cecil M. Peek, M.D. 535 S. Flagler Dr. West Palm Beach	3rd Monday 8:00 P.M.	90	80	D-7-50 Erasmus B. Hardee, M.D. Vero Beach
	St. Lucie-Okeechobee-Martin	Adrian M. Sample, M.D. Box 897 Ft. Pierce	Jerome A. Megna, M.D. 706 S. 6th St. Ft. Pierce	3rd Thursday 8:00 P.M.	13	11	
	Broward	Paul G. Shell, M.D. 420 Sweet Bldg. Ft. Lauderdale	Scottie J. Wilson, M.D. 309 Blount Bldg. Ft. Lauderdale	4th Tuesday 8:00 P.M.	65	61	D-8-51 S. Marion Salley, M.D. Miami
	Dade	John D. Milton, M.D. 1105 Huntington Bldg. Miami	Benjamin G. Oren, M.D. 628 duPont Bldg. Miami	1st Tuesday 8:30 P.M.	502	364	
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Joseph S. Stewart

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*Magladery, J.: Therapeutic Conference, The Treatment of Epilepsy. Bull. Johns Hopkins Hosp., 82:609, (June) 1948.

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Volume XXXV JUNE, 1949 No. 12

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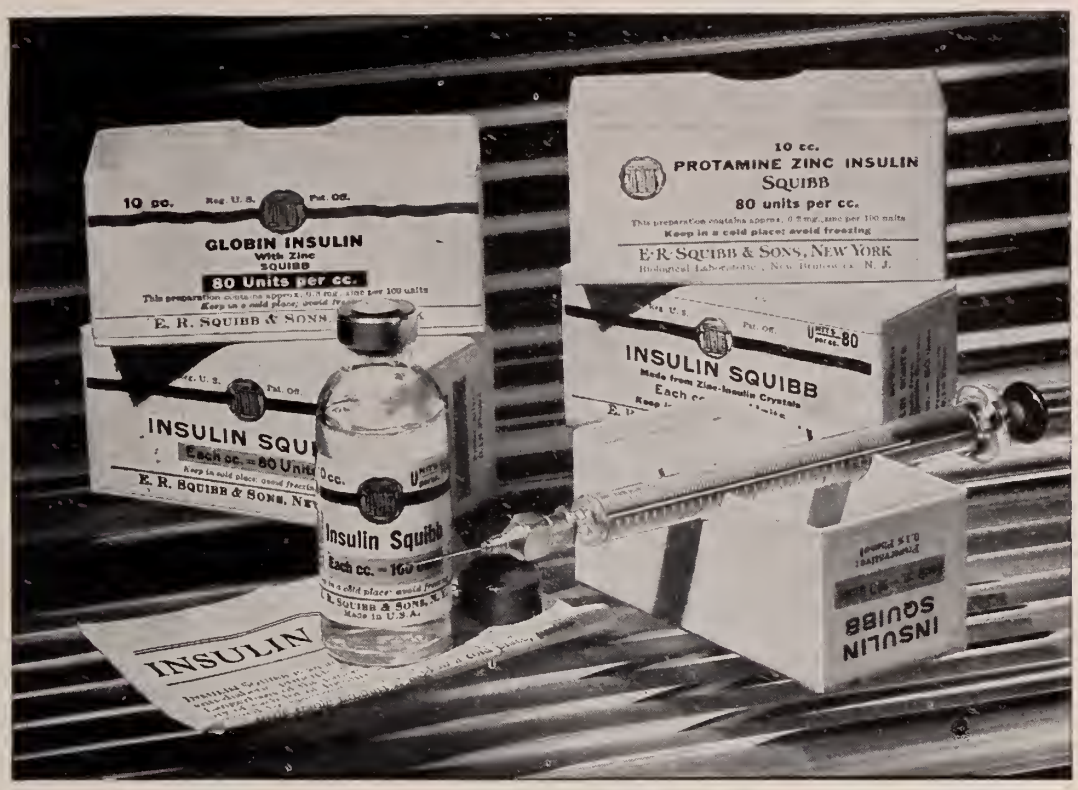
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This Journal is not responsible for the opinions and statements of its contributors.

Published monthly at Jacksonville, Florida. Price $5.00 a year; single numbers, 50 cents. Address Journal of the Florida Medical Association, P. O. Box 1018 (Fla. Theater Bldg.), Jacksonville 1, Fla. Telephone 6-1571. Accepted for mailing at special rate of postage provided for in Section 1103, Act of Congress of October 3, 1917; authorized October 16, 1918. Entered as second-class matter under Act of Congress of March 3, 1879, at the post office at Jacksonville, Florida, October 23, 1924.



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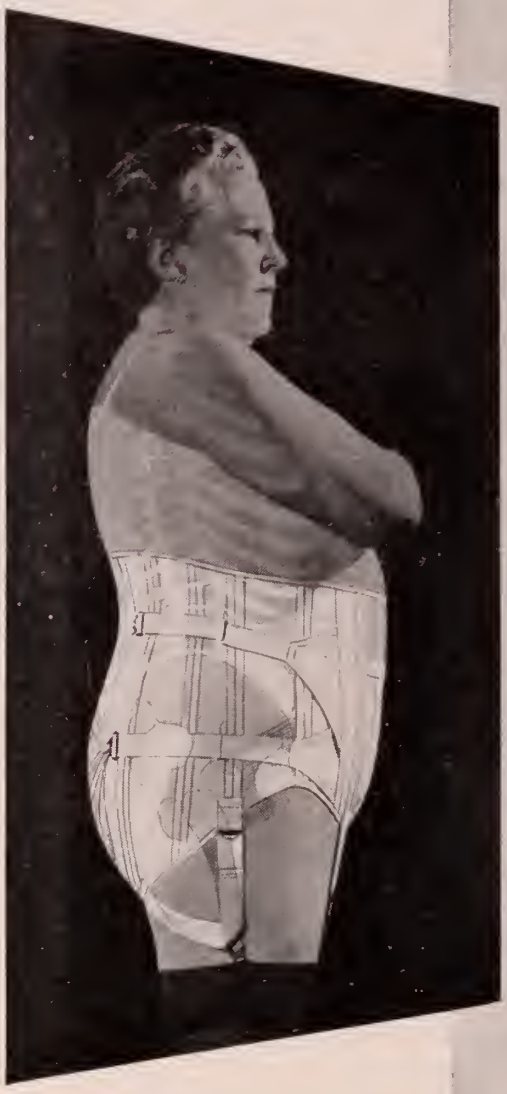
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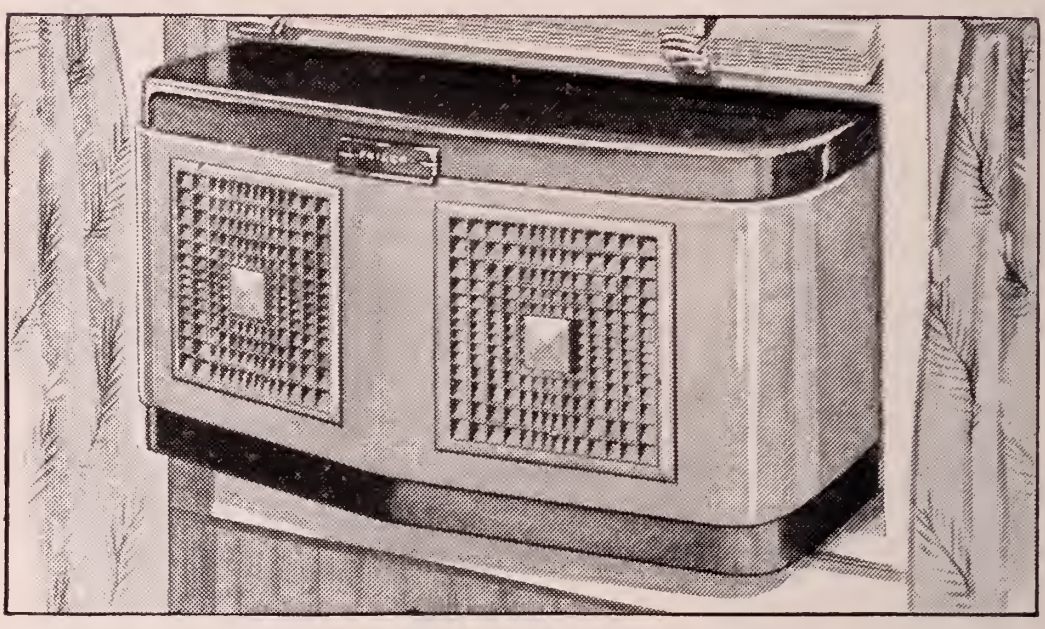
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Council on Pharmacy and Chemistry, A.M.A.
J.A.M.A. 137:789 (June 26) 1948.

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Volume XXXV
Number 12

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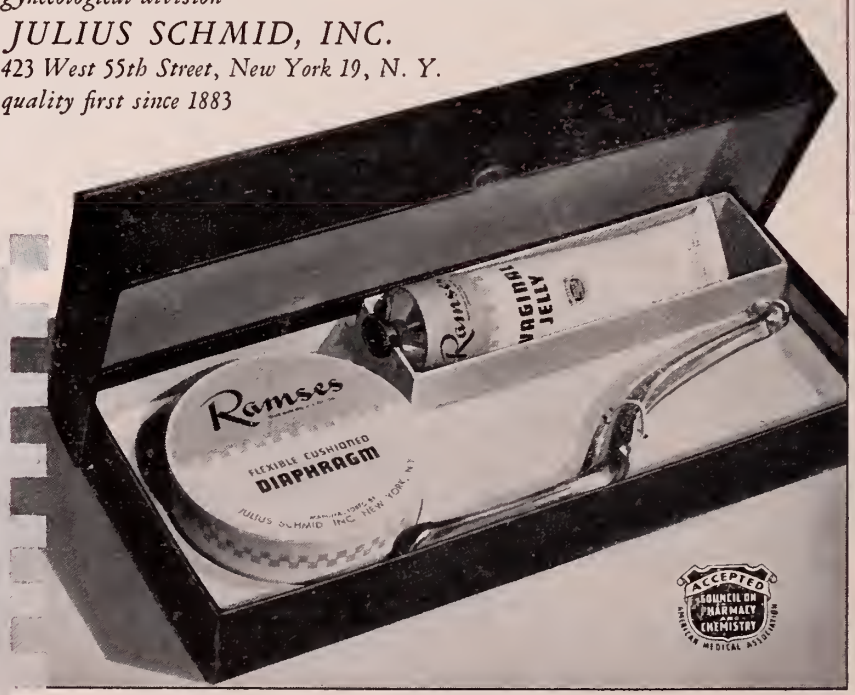
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1. New York State J. Med. 47:1003

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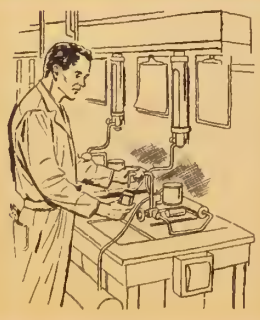
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THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION
PUBLISHED MONTHLY
Volume XXXV Jacksonville, Florida, June, 1949 No. 12

President's Address

The Goal of Medicine

JOSEPH S. STEWART, M.D.
MIAMI

Mr. Vice President, Members of the Florida Medical Association, Ladies and Gentlemen:

The Seventy-Fifth Annual Meeting of the Florida Medical Association is upon us. North Carolina and Pennsylvania held their centennial celebrations last year, and Georgia holds hers next month. Congratulations to our sister states, our seniors by twenty-five years.

Two years ago you gave me the highest honor that is within your power to give. It is a great honor and a great responsibility. Now that my year of service is about over I appreciate to the fullest my inadequacies in living up to the confidence you placed in me. May I again humbly thank you for the privilege of serving organized medicine and for the opportunity of placing my name at the bottom of that long list of names of distinguished Florida doctors who have served as president of this Association.

An integral part in the life of the doctor and in his success or failure is his wife. In our deliberations we give our wives little credit and less acclaim. I wish to pay tribute to my wife and through her to extend the tribute to the wife of every doctor in Florida. For twenty-eight years, Mrs. Stewart, as a doctor's wife, you have lived, with sympathy and understanding, through the inconveniences of interrupted dinners, half finished moving pictures and concerts, sleepless nights and ruined vacations. Through successes and failures, through good times and bad times, through days of despondency and days of elation you have been my companion, my inspiration, my lover. God bless you. God bless our wives.

History

In 1853 organized medicine in Florida came into being. I will quote from an article by Dr. Webster Merritt. "The Florida Republican published, on May 19, 1853, the following significant notice. 'The physicians of Duval County are requested to meet in Jacksonville on Wednesday evening, next, the twenty-fifth instant at the office of Dr. L'Engle, for the purpose of organizing a county medical association.' The meeting was held on that date, an association was formed, and it was named 'The Duval County Medical Society.' " All honor to the doctors of Duval County for the formation of the first county society and for their constant and outstanding leadership in the annals of Florida Medicine ever since.

Dr. John Gorrie was born in 1802 in the West Indies and came to America when one year old. Graduating in Medicine at Fairfield Medical College in New York in 1827, he practiced in Abbeville, S. C., for six years, then moved to Apalachicola, on the Gulf of Mexico, to become resident physician at the Marine Hospital. There he treated many fever cases and he noticed the increased comfort of the patients when they slept in cool rooms. As a result of this observation, John Gorrie devised an air-conditioning apparatus which led him to the accidental discovery of artificial ice. He received a patent on May 6, 1851. Thus was born the first artificial ice-making machine. All glory to Dr. John Gorrie of Apalachicola.

Education

The health of the people of any state does not depend solely on the type of medical care available. Other factors exert profound influences, chief among them being education, environment, housing and nutrition. Organized medicine can have little direct influence on these factors, since they involve the fundamental financial and educational structure of the state. We can, however, definitely influence the type of medical care available to the people. The standard of medical care in any community is equal to and will not exceed the standard of the practitioners of the community. Education of the doctor is, therefore, and must continue to be, the chief concern of organized medicine.

In undergraduate medical education Florida cannot point with pride to its achievements. Flor-

Read before the Seventy-Fifth Annual Meeting of the Florida Medical Association, Belleair, April 11, 1949.

ida cannot stand shoulder to shoulder with its sister states in medical education, because Florida has not accepted its just proportion of responsibility. Young Floridians must seek their medical education in the overcrowded schools of other states. You and I are happy that the Florida Medical Association is doing everything in its power to obtain a Florida Medical School. The problem is in the hands of our legislature.

We have reason to view with considerable satisfaction the progress being made in postgraduate education in Florida. Intern and resident training is showing remarkable progress. Some of our larger hospitals are offering residency training in the various divisions of medicine that will soon be the equal of any such program in the country. I look with some alarm, however, at the overemphasis on specialization and the fetish of board certification. I believe that in our zeal to train specialists, we are forgetting our duty toward training good general practitioners. Let us remember now and always that the general practitioner is the very foundation of medicine and that the specialist is nothing more nor less than his consultant. To those of you who serve on the staffs of our teaching hospitals I recommend that consideration be given to intern or residency training for the young graduate who plans to go into general practice.

While on the subject of specialization let me add, in passing, a word of caution. May I say that I deplore the tendency among some few of our young specialists to set themselves up in their own conceit as above the rest and to charge fees out of all proportion to their experience, ability and judgment and without consideration for the financial status of the patients concerned? In this connection I should like to quote from The Fellowship Pledge of the American College of Surgeons:

> In particular, I pledge myself to pursue the practice of surgery with thorough self-restraint and to place the welfare of my patients above all else; to advance constantly in knowledge by the study of surgical literature, the instruction of eminent teachers, interchange of opinion among associates, and attendance on the important societies and clinics; to regard scrupulously the interests of my professional brothers and seek their counsel when in doubt of my own judgment; to render willing help to my colleagues and to give freely my services to the needy. Moreover, I pledge myself, so far as I am able, to avoid the sins of selfishness; to shun unwarranted publicity, dishonest money-seeking, and commercialism as disgraceful to our profession; to refuse utterly all money trades with consultants, practitioners, makers of surgical appliances and optical instruments, or others; to teach the patient his financial duty to the physician and to expect the practitioner to obtain his compensation directly from the patient; to make my fees commensurate with the service rendered and with the patient's rights; and to avoid discrediting my associates by taking unwarranted compensation.

The yearly postgraduate course of the Florida Medical Association has been most successful, and I have every confidence that we will achieve even greater things in the future. We must, however, consider enlarging our entire program of education. There are many busy practitioners in the state who cannot afford to leave their patients for several days and who therefore are unable to take advantage of the yearly postgraduate course. These men must be reached. Why not take postgraduate short courses to them, by holding half day conferences in the smaller communities? Members of this Association would, I am sure, gladly give their time for such a program. I recommend that the Committee on Medical Postgraduate Course study this idea with its various ramifications and, if found practicable, put it into effect.

In one phase of postgraduate education we, in Florida, have been sadly negligent. We have failed to take cognizance of the need for constant postgraduate instruction and training of the Negro physicians. Though we expect these men by some untold miracle to give proper medical care to their share of the Negro population, we deny them scientific education and training which we could easily and efficiently give.

The health standard of a community is not judged by the standard of the white citizens but by the standard of all the citizens. Of what has America and American Medicine to be proud if one half or three fourths of the population has the highest standard of health in the world while the other half or one fourth has the lowest? It is time for organized medicine in Florida to face these fundamental facts with scientific and logical realism. I aver that it is the duty of the Florida Medical Association and of each member of the Association, to make available to the Negro doctors every possible advantage in scientific medical education and training. This duty is not to the Negro doctors alone, nor to the Negro population alone; it far transcends in importance any limitation to any one group of people since health and medical care are of fundamental importance to every individual in the state. The age-old problem of social equality does not, by any stretch of the imagination, enter into this question of raising the standards of medical care of the Negro.

I recommend to the Florida Medical Association and to its component county medical societies that programs of education be planned and instituted in the larger hospitals that have Negro

wards and that the Negro physicians be invited to specially arranged ward rounds, conferences and intensive courses of instruction.

Health Insurance

Health Insurance, or Prepaid Medical Care Insurance, is here. It is here to stay. Never again will it be considered a luxury because it is no longer a luxury; it is a necessity. The only question is whether we shall have Voluntary Health Insurance with the full cooperation of government, the people and the medical profession or whether we shall have Federal Compulsory Health Insurance, an experiment conceived by politicians, instituted by politicians and controlled by politicians.

American medicine leads the world in scientific attainments. The standards of health of the American people are world-renowned. But this is not enough. As long as there is room for improvement, then improvement must be realized. Until adequate medical and hospital care, regardless of income, has been made available to every man, woman and child in this country, American Medicine cannot rest. This must be our Goal.

Such perfection cannot be attained immediately. Slow growth is necessary. Trial and error methods must be used.

You and I are not naive enough to believe that voluntary insurance is the sole answer to this great problem. We must plan for those who cannot afford to pay for voluntary insurance. We must plan for those who through ignorance or lack of thrift will not pay for voluntary insurance. And as rapidly as possible we must increase the scope of coverage of our voluntary plans. These are problems for the immediate future. The answers require brains, planning, money, cooperation and leadership.

What can you do now, today, to further best the attainment of the Goal of Medicine? I say to you that our immediate objective is to encourage the purchase of hospital and medical care insurance. There lies your duty.

Federal Compulsory Health Insurance

Foremost in our thoughts today is the fight against Federal Compulsory Health Insurance. The battle is going well. In so far as the Florida Medical Association is concerned, everything now lies in the hands of the component county medical societies. Let each man do his part and we shall win. But if you fail, the people of this nation will lose.

I should like to express the gratitude of the Association to the Woman's Auxiliary and to its component auxiliaries to the county medical societies for the invaluable help they are giving us in this, our hour of need.

When we have won this first skirmish, that is, the defeat in the present Congress of the Truman-Ewing "rationed medicine" proposals, the second phase of the battle begins. American Medicine must then make plans and proposals relating to the economics of medical care, medical education and health standards that will influence for the next hundred years the health of the American people and the history of the United States. Let us but defeat this attempt to socialize the country, then American Medicine, in the American way, will lead this nation into the finest type of medical care, the highest standards of health, and the greatest system of medical education the world has ever known. Then and not until then will Medicine have fulfilled its duty. This achievement will require leadership, better leadership in the economics of medical care than American Medicine has yet demonstrated. It will require a new leadership, realistic, studious and practical, a leadership that can bring into one great plan the concerted efforts of medicine, government, management, labor, business and all the people, rich and poor, young and old. I challenge the delegates from Florida and from all the other states to guarantee to the medical profession of the country and to the people of America the type of medical leadership that will carry us gloriously and successfully through this, the greatest opportunity American Medicine may ever have.

In conclusion, may I remind you that Medicine stands at the crossroads. The greatness of our scientific achievement is belittled by the mediocrity of our economic thinking. Medicine must fight. Let each of us remember that the fight is not for the benefit of the doctor or the doctor's income. No, it is more far reaching and of more fundamental importance than any such trivial consideration. This is a fight for the future health of the American people, for the freedom of Americans. This is a fight for progress. With science and logic in one hand and with God and humility in the other, we shall carry on this fight and we shall win it for America, our Country.

PROCEEDINGS
Seventy-Fifth Annual Meeting

of the

FLORIDA MEDICAL ASSOCIATION
HELD AT BELLEAIR
APRIL 11, 12, and 13, 1949

GENERAL SESSIONS

First General Session

The Seventy-Fifth Annual Meeting of the Florida Medical Association was called to order at 9:20 a.m., Monday, April 11, in The Starlight Room of the Belleview-Biltmore Hotel, Belleair, by President Joseph S. Stewart.

Invocation was pronounced by The Reverend D. P. McGeachy, Jr., Th.D., Minister of Peace Memorial Presbyterian Church, Clearwater.

Dr. William M. Rowlett, president of Hillsborough County Medical Association, and Dr. Francis H. Langley, president of Pinellas County Medical Society, gave addresses of welcome.

There being no new business or announcements the First Session adjourned.

Second General Session

The meeting of the Florida Medical Association reconvened at 2:00 p.m., Monday, April 11, in the Belleview-Biltmore Hotel; President Stewart in the Chair.

The meeting was called to order.

Dr. Herbert E. White, first vice president, took the Chair and called on Dr. Joseph S. Stewart to deliver the presidential address. (See page 759).

Dr. White relinquished the Chair and turned the gavel over to President Stewart.

The following report of the secretary-treasurer and managing director was read by Dr. McIver:

Report of Secretary-Treasurer, Dr. Robert B. McIver, and Managing Director, Dr. Stewart G. Thompson

Mr. Chairman, Members of the Association and Guests:

The Association's membership during the past year reached an all time high with a total of 1,954. The record for the previous year was 1,849, which represents an increase of 105 members. The following members are not required to pay state dues: life members, 81; honorary members, 47; in military service, 11; and secretaries of county medical societies, 35, making a total of 174.

The five county medical societies ranking highest in total membership are Dade 501, Duval 240, Pinellas 162, Hillsborough 151 and Orange 136.

Receipts for the fiscal year total $66,557.46. Disbursements, $56,783.52. Earmarked for public relations is $12,700.00. These two items total $69,483.52; therefore, the Association's operating account is in the red $2,926.06. Forty per cent of the annual dues collected is appropriated to the Bureau of Public Relations. The Association's general activities over the past few years have been increased and enlarged until there is a heavy load to carry that requires a large income. If it were not for the additional revenue obtained through advertising in The Journal and Medical Directory, sales of these publications, rental on exhibit booths at conventions, and placing the Smoker on a pay-as-you-go basis, it would be impossible to operate without a major increase in the state dues. Extreme care is taken to utilize every dollar as economically as possible for all expenditures, and great effort has been put forth to increase the revenue through activities at the headquarters office.

Medical Directory

The 1949 Florida Medical Directory was mailed to the members of the Association in January. This is the twelfth edition of the Directory which is published annually.

In the Preamble on page 5 it will be noted that a separation is made of the total for resident doctors and nonresident doctors. You are urged to bear this in mind as many misstatements as to the number of doctors practicing in Florida has been made from time to time. Of the 4,040 doctors licensed to practice in Florida only 2,701 are living in the state.

A new feature is the addition of symbols in the hospital list on page 46. At the 1948 meeting of the House of Delegates, on recommendation of the Association's committee on Medical Education and Hospitals, action was taken to indicate by symbols in the list of hospitals those that are approved by the American Medical Association and the American College of Surgeons for internship, residencies, etc.

The demand for Directories is steadily increasing. In 1949 it was necessary to purchase 2,700 Directories. Advertising and sales of the Directory netted $1,498.00.

Bureau of Public Relations

During the fiscal year ending March 15, 1949, a total of $5,160.00 was turned over to the Florida Academy of Public Medicine. There is a cash balance in the Bureau of Public Relations account of $12,700.00, which is available for the public relations program as needed.

Medical Postgraduate Course Committee

Monies received by this committee for registration fees, etc., are deposited in a special fund and disburse-

ments are made to Dr. Turner Z. Cason, chairman, as requested. No itemized account is kept on receipts and disbursements in accordance with an action of the Board of Governors, September 21, 1947. As of close of the books this year there is a balance on hand of $991.58.

The Journal

The circulation of The Journal increases in proportion to the number of new members coming into the Association. For the past fiscal year 26,548 Journals were purchased. Collections from advertising approximately covers the actual printing costs of The Journal. During the past fiscal year $12,288.20 was collected from advertising as compared with $13,997.97 for the previous year. There is a small decrease in the revenue from advertising which was anticipated. In fact, advertising did not fall off as much as was expected.

The major part of the advertising income is obtained through the Cooperative Medical Advertising Bureau which is composed of the editors of state medical journals who hold membership in the Bureau. The journals for New York, Illinois and California are not included.

The mechanics and business operations are handled by Dr. Stewart Thompson, managing editor, under the supervision of Dr. Shaler Richardson, the editor, who sets all policies for The Journal.

Association's Office

In spite of additional office space obtained last year, all rooms in the Association's headquarters office are now crowded. The Association's activities are expanding continually which adds to the load carried by the staff in the central office.

Although the Public Relations Bureau is set up as a unit, a large proportion of the mail routes through the Association's office, and all state dues are collected through it. The Bureau activities are so closely connected with the Association's office that it requires a great deal of the time of Dr. Thompson, managing director.

Another additional load now carried in the office is the collection of the $25.00 assessment made by the A. M. A. To date $23,675.00 has been received from our members and forwarded to the A. M. A. When remittances are received from the county medical societies, a covering letter and the checks are forwarded to the A. M. A., and a copy of the letter is mailed to the secretary of the county medical society that forwarded the remittances. If an individual check is received from a member, it is forwarded to the A. M. A. and a copy of the covering letter is mailed to the individual member; also, a copy is mailed to the secretary of his county medical society. The individual checks of the members are received from the county medical societies and each check must be carefully scrutinized to see that it is made out to the A. M. A., properly signed, etc. The volume of checks going through the office is no small item. A separate book is maintained reflecting the amounts received, but no record is kept for the A. M. A. of the individual doctors who pay the assessment.

The following employees should receive commendation for their splendid service and loyalty: Mr. Nelson P. Moyer, assistant managing director, Mrs. Zoe Pack, chief clerk, Miss Dorothy Shea, journal technician, Mrs. Frances Richards, stenographer, Mrs. Edith Hill, manuscript editor. Mrs. Hill is on a part time basis and not in the office. Mrs. Naomi Hilton, a former employee, checks the Association's books each month and assists during annual conventions.

Finances

Revenue is largely received from the following sources: dues and entrance fees, $46,430.00; advertising and sales of Journals, $12,507.45; advertising and sales of Directories, $1,498.00; rental of exhibit booths, $5,830.00.

The financial statements appearing at the end of this report will be published in full for the benefit of members who wish to study the details.

The books and records of the Association are open to the members and we will be glad to answer inquiries of any nature as far as possible. The books have been audited by Charles H. Goodrich, Certified Public Accountant, and a certification of the audit is incorporated in the statements which follow.

Respectfully submitted,
Robert B. McIver, *Secretary-Treasurer*
Stewart G. Thompson, *Managing Director*

Consolidated Cash Statement

March 16, 1948 through March 15, 1949

Receipts

Cash in Bank, March 16, 1948		$30,515.24
Dues and Entrance Fees Collected (Exhibit "D")	$46,430.00	
Earnings from Journal Advertising (Exhibit "B")	12,288.20	
Subscription and Misc. Sale of Journal (Exhibit "B")	219.25	
Earnings from Directory Advertising (Exhibit "E")	1,020.00	
Directory Sales (Exhibit "E")	478.00	
Interest on Savings and Investment Income—Retirement Trust Fund	72.32	
Miscellaneous Income	96.74	
Profit from Reprints (Non-Members)	4.45	
Earnings from Technical Exhibits (Exhibit "C")	5,830.00	66,557.46
Total Cash to be Accounted for		$97,072.70

Disbursements

General Fund Expenses (Exhibit "A")	$ 4,682.01	
Journal Expenses (Exhibit "B")	11,355.74	
Directory Expenses (Exhibit "E")	1,300.42	
Technical Exhibit Expenses (Exhibit "C")	3,889.65	
Committee Expenses (Exhibit "A")	2,022.95	
Federal Tax	296.51	
Purchase Bonds (Series F)	4,800.00	
Library	77.00	
Furniture and Fixtures	718.70	
Bureau of Public Relations	5,160.00	
Payrolls	20,501.81	
To Entertaining Society (St. Johns)	1,978.73	56,783.52
Balance in Bank, March 15, 1949		$40,289.18

Assets and Liabilities

March 15, 1949

Assets

Cash in Fla. Natl. Bank Checking Acct.	$30,243.02
Cash in Barnett Natl. Bank Checking Acct. (Postgraduate Course Committee Acct.)	991.58
General Fund—Accounts Receivable	13,475.00
Journal Fund—Accounts Receivable	1,100.04
Furniture, Fixtures and Equipment (less depreciation)	2,489.45
Library	1,145.67
Stationery Inventory	1,459.84
Atlantic Natl. Bank (Retirement Trust Fund)	8,172.32
Savings: Atlantic Natl. Bank	9.17
Barnett Natl. Bank	1,864.67
Investments: Treasury Bond	14,800.00
War Savings Bonds	15,040.50
	$90,791.26

Liabilities

Bureau of Public Relations	$12,700.00
Postgraduate Course Committee	991.58
Capital	77,099.68
	$90,791.26

Exhibit "A"
Cash Statement—General Fund
March 16, 1948 through March 15, 1949

Receipts

Cash as per last audit		$30,515.24
Back Dues Collected (Exhibit "D")	$13,625.00	
Current Dues Collected (Exhibit "D")	31,025.00	
Entrance Fees Collected (Exhibit "D")	1,780.00	46,430.00
Interest on Savings and Investment		118.50
Income—Retirement Trust Fund		72.32
Miscellaneous Income		96.74
From Journal Fund (Income above Cost)		1,156.16
From Directory Fund (Income above Cost)		197.58
Total Cash to be Accounted for		$78,586.54

Disbursements

Postage and Supplies	$ 829.17	
Telephone and Telegraph	437.70	
Traveling Expense	572.39	
Delegates' (2) Transp. Chicago and St. Louis	458.74	
Office Rent	1,682.50	
Towel Service	19.00	
Auditing Books	20.00	
Porter Service	2.45	
Express and Freight	5.59	
Bank Exchange	5.45	
Custody of Bonds	10.00	
Clipping Service	145.00	
Treasurer's Bond	37.50	
Employer's Liability Insurance	18.72	
Subscription—Times-Union	18.20	
Repair & Service—Furn., Fix., & Equipment	111.10	
Rental—Safety Deposit Box	15.00	
Blue Cross and Blue Shield	114.30	
Incidental	179.20	4,682.01
Committees:		
Council	151.68	
Board of Governors	186.90	
Legislation and Public Policy	1,328.92	
Scientific Work	14.76	
Miscellaneous Committee Expense	340.69	2,022.95
Bureau of Public Relations (B.P.R. Exhibit)		5,160.00
Federal Tax		296.51
Furniture and Fixtures		718.70
Library		77.00
Payrolls*		20,501.81
Purchase Bonds (Series F)		4,800.00
To Exhibit Fund (cost above income)		38.38 $38,297.36
Cash Balance		$40,289.18

*Total Payroll. Income tax deducted from this amount and paid to Collector of Internal Revenue.

Exhibit "B"
Cash Statement—Journal Fund
March 16, 1948 through March 15, 1949

Receipts

Cash as per last audit		$ 0.00
Earnings from Advertising	$12,288.20	
Subscription and Misc. Sale	219.25	
Profit from Reprints (Non-Members)	4.45	12,511.90
To be Accounted for		$12,511.90

Disbursements

Postage and Supplies	$ 348.79	
Printing and Stock	10,592.18	
Telephone and Telegraph	247.39	
Dray	61.80	
Auditing Books	20.00	
Incidental	85.58	
	11,355.74	
To General Fund (Income above Cost)	1,156.16	$12,511.90
Cash Balance		$ 0.00

Exhibit "C"
Cash Statement—Exhibit Fund
March 16, 1948 through March 15, 1949

Receipts

Cash as per last audit		$ 0.00
Earnings from Technical Exhibits		5,830.00
From General Fund (cost above income)		38.38
To be Accounted for		$5,868.38

Disbursements

Convention Expense:		
Telephone and Telegraph	$ 172.47	
Exhibit Booth Equipment	2,311.98	
Honorarium—Guest Speaker	100.00	
Programs	131.10	
Badges	147.56	
Misc. Expense & Employees' Travel	482.08	
News Service, Cuts & Mats	49.81	
Proceedings Reporter	78.20	
Theatre Rental for Scientific Program	75.00	
Annual Dinner, Cocktails, etc.	310.80	
Printing	30.65	
	3,889.65	
To Entertaining Society (St. Johns)	1,978.73	5,868.38
Cash Balance		$ 0.00

Exhibit "E"
Cash Statement—Directory Fund
March 16, 1948 through March 15, 1949

Receipts

Cash as per last audit		0.00
Earnings from Advertising	$1,020.00	
Sales	478.00	$1,498.00
To be Accounted for		$1,498.00

Disbursements

Postage and Supplies	$ 101.50	
Printing and Stock	1,192.20	
Telephone and Telegraph	1.52	
Incidental	5.20	
	$1,300.42	
To General Fund (income above cost)	197.58	$1,498.00
Cash Balance		$ 0.00

Exhibit "D"
Dues and Entrance Fees Collected March 16, 1948 Through March 15 1949

Name of Society	Total Members	No. Paid Members	No. In Arrears	1949 Dues Collected	Back Dues Collected	Entrance Fees
Alachua	37	33	4	650.00	750.00	70.00
Bay	15	7	8	150.00	225.00	20.00
Brevard	14	14	0	300.00	100.00	20.00
Broward	64	59	5	1,325.00	125.00	30.00
Columbia	16	16	0	375.00		30.00
Dade	501	303	198	7,075.00	4,250.00	460.00
DeSoto-Hardee-Highlands-Charlotte-Glades	29	27	2	600.00	25.00	50.00
Duval	240	176	64	3,725.00	2,275.00	210.00
Escambia	61	8	53	25.00	300.00	30.00
Franklin-Gulf	7	5	2	100.00	100.00	30.00
Hillsborough	151	93	58	1,925.00	650.00	130.00
Indian River	8	8	0	175.00	50.00	
Jackson	18	15	3	300.00	50.00	20.00
Lake	21	2	19		275.00	20.00
Lee	23	19	4	425.00	125.00	40.00
Leon-Gadsden-Liberty-Wakulla-Jefferson	45	39	6	825.00	150.00	20.00
Madison-Suwannee	11	10	1	200.00	75.00	40.00
Manatee	18	1	17		75.00	
Marion	28	25	3	450.00	150.00	10.00
Monroe	14	14	0	300.00	75.00	30.00
Nassau	9	9	0	175.00	50.00	20.00
Orange	136	109	27	2,500.00	325.00	90.00
Palm Beach	91	75	16	1,800.00	625.00	100.00
Pasco-Hernando-Citrus	12	10	2	200.00	50.00	40.00
Pinellas	162	159	3	3,550.00	175.00	120.00
Polk	76	62	14	1,450.00	1,750.00	50.00
Putnam	9	9	0	200.00	50.00	10.00
St. Johns	15	14	1	275.00		
St. Lucie-Okeechobee-Martin	13	11	2	250.00	425.00	30.00
Sarasota	23	4	19		100.00	10.00
Seminole	11	11	0	250.00		10.00
Taylor	4	3	1	50.00		
Volusia	53	46	7	1,000.00	250.00	30.00
Walton-Okaloosa	14	14	0	300.00		10.00
Washington-Holmes	5	5	0	100.00		
Totals	1,954	1,415	539	$31,025.00	$13,625.00	$1,780.00

Dues Not Payable			
Co. Soc. Secys.	35		
Life	81		
Honorary	47		
Military Service	11	174	
Paying Dues		1,241	

$13,625.00 Back Dues Collected
$44,650.00 Total Dues Collected
1,780.00 Entrance Fees Collected
$46,430.00 Dues and Entrance Fees

Medical Postgraduate Course Committee—VII
March 16, 1948 through March 15, 1949

Receipts

Cash as per last audit	$1,366.58
Registration Fees, etc., 1948 Postgraduate Course	3,325.00
To be Accounted for	$4,691.58

Disbursements

Dr. T. Z. Cason, Chairman—Expenses	$3,700.00
Balance in Bank	$ 991.58

Bureau of Public Relations—III
March 16, 1948 through March 15, 1949

Receipts

Cash Balance	$ 0.00
Dues Collected 1948—$13,625.00; 1949—$31,025.00, Total $44,650.00 (Exhibit "D") Two-Fifths—1,786 @ $10.00	17,860.00
To be Accounted for	$17,860.00

Disbursements

Florida Academy of Public Medicine	$ 5,160.00
Cash Balance	$12,700.00

Dr. Robert B. McIver
Secretary-Treasurer
Florida Medical Association
Jacksonville, Florida

Dear Sir:

In compliance with request of Stewart G. Thompson, Managing Director, we have examined the following:

Statement of Assets and Liabilities—March 15, 1949.
Consolidated Cash Statement—March 16, 1948 to March 15, 1949.
Exhibits A to E inclusive.
Statement of Receipts and Disbursements—Bureau of Public Relations—March 16, 1948 thru March 15, 1949.
Statement of Receipts and Disbursements—Medical Postgraduate Course VII—March 16, 1948 thru March 15, 1949.

all of Florida Medical Association, Inc.

These statements and exhibits have been found in agreement with the books of account of the Association and correctly reflect the recorded cash transactions for the period.

All recorded receipts covering cash collections were traced to the bank deposits and all bank balances have been reconciled with the books of account and independently verified by the depositories.

Cancelled checks covering disbursements were checked to the records, found in order and appeared to be for proper purposes.

War Bonds of a maturity value of $40,325.00 were verified by inspection.

Income from advertising in the Association's Journal was verified substantially by comparison with records.

On account of the inacessibility of the records of the various County Societies, no attempt was made to verify remittances for dues.

Yours very truly,
(Signed) Goodrich & Varnedoe
Certified Public Accountants

CHG/d

The following report of the Editor of The Journal was read by Dr. Shaler Richardson.

Report of Editor of The Journal

Dr. Shaler Richardson

As The Journal goes into its thirty-sixth year, its contrast to the first number in 1914 is as striking as that between the 1949 automobile and the Hupmobile advertised in the first issue. As you noticed in the November 1948 issue, The Journal has a new cover design on shiny kromekote which surpasses any covers during The Journal's existence. We hope that you were pleased with the innovation. To be completely convinced of its attractiveness, you would have to see it on display with the other state journals.

The most recent monthly circulation figure is 2,200 Journals. Of these, 1,897 go to active members of the Association and 303 to advertisers, exchanges and subscribers.

The publication of material during the past year has been in keeping with the policies heretofore. It is primarily an outlet for original articles written by members of the Association. During the past year 37 papers written by members and 4 written by guest authors have been published.

The policy of abstracting articles written by members and published in journals other than our own has been continued. Last year 25 abstracts were published. It has been our intention to enlarge the abstract department and we invite members to mail reprints of their articles, published elsewhere, to the Association office so that they may be prepared for abstracting.

In the editorial section we have endeavored to present material which would be thought-provoking and which would epitomize the trend of the practice as it progresses. Special commendation is to be given Dr. Webster Merritt, assistant editor, who has taken an active interest in writing editorials. He has consistently pounded at the socialization of medicine in his editorials and has also presented other pertinent thoughts for your consideration. The tone of the editorial section, we believe, is one of which we can be proud.

We wish to urge secretaries of county medical societies to take a more active interest in the section devoted to society news. Each society meeting involves newsworthy material. Other news concerning professional activities of members should be forwarded for the column of state news.

My personal appreciation for their cooperation goes to Drs. Arthur L. Walters and Herman Watson, committee on publication, and to Dr. Kenneth A. Morris, chairman of the abstract department.

The Journal is yours and reflects each of you. It can only mirror that which is placed before it.

Respectfully submitted,
Shaler Richardson, *Editor*

There were no delegates present from other state societies.

There being no new business or announcements the Second General Session adjourned.

Third General Session

The meeting of the Florida Medical Association reconvened at 11:30 a.m., Tuesday, April 12, in the Belleview-Biltmore Hotel; President Stewart in the Chair.

The meeting was called to order.

The guest speaker, Dr. Cushman D. Haagensen, Associate Professor of Clinical Surgery, Columbia University College of Physicians and Surgeons, New York, was introduced by President Stewart.

Address: "Diagnosis of Cancer of the Breast" by Dr. Haagensen.

President Stewart expressed his appreciation of Dr. Haagensen's excellent presentation.

There being no further business or announcements the Third General Session adjourned.

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HOUSE OF DELEGATES

First House of Delegates

The House of Delegates convened at 2:25 p.m., Tuesday, April 12, 1949, in The Starlight Room of the Belleview-Biltmore Hotel, Belleair. Dr. Joseph S. Stewart, President, in the Chair.

Dr. Louis M. Orr, II, chairman of the Credentials Committee, was recognized and reported the following delegates whose credentials were in order and attendance cards signed.

Delegates

ALACHUA—Edwin H. Andrews, Walter E. Murphree
BAY—William C. Roberts
BREVARD—Thomas C. Kenaston
BROWARD—Richard A. Mills, Robert L. Elliston, Claus A. Peterson
COLUMBIA—Harry S. Howell
DADE—John D. Milton, Charles R. Burbacher, Reuben B. Chrisman, Jr., M. Jay Flipse, Carl E. Dunaway, Homer L. Pearson, Jr., Gerard Raap, Ralph W. Jack, Walter C. Jones, C. Russell Morgan, Jr., Alfred G. Levin, Jack Q. Cleveland, Donald F. Marion, Raymond L. Evans, Frazier J. Payton, Colquitt Pearson, Ralph S. Sappenfield, Donald W. Smith, Robert T. Spicer, Kenneth Phillips, Arthur H. Weiland, W. Duncan Owens
DeSOTO - HARDEE - HIGHLANDS - CHARLOTTE-GLADES—Roland W. Banks
DUVAL—Leo M. Wachtel, Jr., Raymond H. King, Raymond R. Killinger, William H. Brooks, Edward Canipelli, John F. Lovejoy, James L. Borland, Charles F. Henley, Karl B. Hanson, John A. Beals, Frank L. Fort, Edward Jelks
ESCAMBIA—Herbert L. Bryans, Jesse N. McLane, Alvin L. Stebbins
FRANKLIN-GULF—*(No delegate)*
HILLSBOROUGH—Leland F. Carlton, Herschel G. Cole, William G. Meriwether, H. Phillip Hampton, Samuel G. Hibbs, David R. Murphey, Jr., William M. Rowlett
INDIAN RIVER—Erasmus B. Hardee
JACKSON—Courtland D. Whitaker
LAKE—Rabun H. Williams
LEE—H. Quillian Jones
LEON - GADSDEN - LIBERTY - WAKULLA-JEFFERSON—George H. Garmany, Taylor W. Griffin
MADISON-SUWANNEE—A. Franklin Harrison
MANATEE—Lowrie W. Blake
MARION—Henry L. Harrell
MONROE—*(No delegate)*
NASSAU—John M. McDonald
ORANGE—David Y. Hicks, Jr., Eugene L. Jewett, William S. Mitchell, Louis M. Orr, II, Duncan T. McEwan
PALM BEACH—Victor Clarholm, Lloyd J. Netto, Frederick K. Herpel, Vale D. Stone
PASCO-HERNANDO-CITRUS—George R. Creekmore
PINELLAS—Francis H. Langley, George H. Anderson, M. Eldridge Black, William M. Davis, John P. Ferrell, William D. Futch, H. Milton Rogers
POLK—Jere W. Annis, Wiley T. Simpson, Robert J. Jahn
PUTNAM—Grover C. Collins
ST. JOHNS—Hardgrove S. Norris
ST. LUCIE-OKEECHOBEE-MARTIN—Adrian M. Sample
SARASOTA—John M. Butcher
SEMINOLE—Frank L. Quillman
TAYLOR—Walter J. Baker
VOLUSIA—Vaughan A. Shaw, Cleland D. Cochrane, Joseph E. Taylor
WALTON-OKALOOSA—Henry C. White, Jr.
WASHINGTON-HOLMES—*(No delegate)*
ASSOCIATION OFFICERS—Joseph S. Stewart, Walter C. Payne, Herbert E. White, Reddin Britt, Robert B. McIver, Shaler Richardson

The Chair suggested that a vote of thanks be extended to the members of the Credentials Committee for its fine cooperation. Motion made, seconded and carried.

On motion by Dr. Orr and seconded by Dr. Rowlett, the minutes as published in the June 1948 Journal were approved.

The Chair called for election of one delegate and one alternate to the A. M. A. to serve for a two year term beginning January 1, 1950 and ending December 31, 1951.

Dr. Louis M. Orr, II, was nominated to succeed himself for another two year term. It was moved and seconded that the nominations close. Motion carried. Motion was made and seconded that Dr. Orr be elected as delegate. Motion carried.

Dr. William M. Rowlett nominated Dr. Joshua C. Dickinson as alternate delegate. It was moved and seconded that the nominations close. Motion carried. It was moved and seconded that Dr. Dickinson be elected alternate delegate. Motion carried.

Dr. Walter C. Payne was recognized and requested a discussion on the Lister-Hill Bill.

The Chair advised that although the Florida Medical Association has taken no action in favor of this bill, he as president wished to state that he felt the Association was heartily in favor of it.

The Chair announced that Dr. Homer L. Pearson, Jr., delegate to the A. M. A. House of Delegates, was just back from Chicago and asked that he discuss the bill.

Dr. Pearson was recognized and in his discussion brought out that the bill was designed principally to care for the indigent and the near-indigent in assisting them to carry hospital and health insurance.

The Chair announced that personnel of the three reference committees may be found on page 5 of the Handbook, and made the following changes: On Reference Committee No. 2, Public Policy, Dr. William M. Rowlett to replace Dr. William C. Blake who was absent.

On Reference Committee No. 3, Finance and Administration, Dr. Arthur H. Weiland to replace Dr. S. Charles Werblow who was absent.

Personnel of the three reference committees are as follows:

1. HEALTH AND EDUCATION
Room No. 11
Edward Jelks, *Chairman*
Frazier J. Payton
Robert L. Elliston
Edwin H. Andrews
Frederick K. Herpel

2. PUBLIC POLICY
Room No. 29
H. Quillian Jones, *Chairman*
William M. Rowlett
Louis M. Orr, II
Lloyd J. Netto
Herbert E. White

3. FINANCE AND ADMINISTRATION
Room No. 9
Shaler Richardson, *Chairman*
Erasmus B. Hardee
Walter C. Payne
George H. Garmany
Arthur H. Weiland

The Chair announced that reports of standing committees as printed in the Handbook are referred to reference committees as follows:

1. HEALTH AND EDUCATION

Committee on Medical Postgraduate Course
Committee on Cancer Control
Committee on Venereal Disease Control
Committee on Tuberculosis and Public Health
Committee on Maternal Welfare
Committee on Child Health
Committee on Conservation of Vision

2. PUBLIC POLICY

Committee on Medical Education and Hospitals
Committee on Necrology
Committee on Medical Economics
Committee on Interrelationship
Committee on State Controlled Medical Institutions
Representatives to Industrial Council

3. FINANCE AND ADMINISTRATION

Delegates to AMA Interim Session
Board of Governors
Committee on Scientific Work
Committee on Legislation and Public Policy
Committee on Public Relations
Committee on Advisory to Woman's Auxiliary Council

The Chair requested the chairman of Reference Committee No. 1, Health and Education, to prepare for presentation a resolution of appreciation to those responsible for the success of the Seventy-Fifth Annual Meeting.

Dr. Jack Q. Cleveland presented a resolution concerning the practice of Medical Technology. This was referred by the Chair to Reference Committee No. 1, Health and Education.

Dr. Leigh F. Robinson presented a resolution concerning the instruction of delegates to the A. M. A. in regard to the Blue Shield Commission's place in the A. M. A. Public Relations Program. This was referred by the Chair to Reference Committee No. 2, Public Policy.

Dr. Leigh F. Robinson presented a resolution on supporting proposal for a National Service Plan as proposed by the Blue Shield Commission, which was referred by the Chair to Reference Committee No. 2, Public Policy.

Dr. Herbert L. Bryans presented a resolution relative to the practice of naturopathy, which was referred by the Chair to Reference Committee No. 1, Health and Education.

Dr. Alvin L. Stebbins presented a resolution relative to the State Board of Health releasing thirty sanitary inspectors of eating places, thereby constituting a saving of $126,000. This was referred by the Chair to Reference Committee No. 2, Public Policy.

Dr. Vaughan A. Shaw presented a resolution relative to the teaching of anatomy and physiology, which was referred by the Chair to Reference Committee No. 1, Health and Education.

A resolution by Dr. John D. Milton opposing compulsory health insurance was referred by the Chair to Reference Committee No. 3, Finance and Administration.

Dr. Edward Jelks presented a resolution opposing compulsory health insurance, which was referred by the Chair to Reference Committee No. 3, Finance and Administration.

A resolution presented by Dr. Edward Jelks approving Florida Committee on Fetus and the Newborn was referred by the Chair to Reference Committee No. 1, Health and Education.

Dr. Lloyd J. Netto presented a resolution relative to increase of Industrial Fee Schedules. This was referred by the Chair to Reference Committee No. 2, Public Policy.

Dr. Roland W. Banks presented a resolution concerning the use of special containers for poisons, which was referred by the Chair to Reference Committee No. 1, Health and Education.

Dr. M. Jay Flipse was recognized by the Chair and presented a report of a special committee which had been appointed by the president to act as advisors to the Florida Association of Medical Technologists. This was referred by the Chair to Reference Committee No. 1, Health and Education.

The supplemental report of the Board of Governors was presented by Dr. Duncan T. McEwan, Chairman. This was referred by the Chair to Reference Committee No. 3, Finance and Administration.

A supplemental report of the Committee on Legislation and Public Policy was presented by Dr. W. Duncan Owens. This was referred by the

Chair to Reference Committee No. 3, Finance and Administration.

Dr. Alfred G. Levin presented a supplemental report of the Committee on Cancer Control. This was referred by the Chair to Reference Committee No. 1, Health and Education.

Dr. John M. Butcher, Councilor for District 5, was recognized by the Chair and extended the courtesy of the floor to present a supplemental report of the Council for Dr. Herman Watson, Chairman, who was absent. The Chair referred this to Reference Committee No. 3, Finance and Administration.

The report of the Committee on Maternal Welfare, which was received too late for printing in the Handbook, was read by the Secretary and referred by the Chair to Reference Committee No. 1, Health and Education.

The secretary, Dr. Robert B. McIver, made a brief announcement.

Dr. Robert T. Spicer, president of the Florida Academy of Public Medicine, was recognized by the Chair and made an announcement.

There being no further business, the House recessed at 3:30 p.m., to reconvene at 10:30 a.m., Wednesday, April 13, 1949.

Second House of Delegates

The House of Delegates reconvened at 10:40 a. m., Wednesday, April 13, in The Starlight Room of the Belleview-Biltmore Hotel, Belleair; President Stewart in the Chair.

Dr. Louis M. Orr, II, chairman of the Credentials Committee, was recognized and reported that the following delegates were present and had signed attendance cards.

Delegates

ALACHUA—Edwin H. Andrews, Walter E. Murphree
BAY—William C. Roberts
BREVARD—Thomas C. Kenaston
BROWARD—Richard A. Mills, Robert L. Elliston, Claus A. Peterson
COLUMBIA—Harry S. Howell
DADE—John D. Milton, Charles R. Burbacher, Reuben B. Chrisman, Jr., M. Jay Flipse, Carl E. Dunaway, Homer L. Pearson, Jr., Gerard Raap, Ralph W. Jack, Walter C. Jones, Alfred G. Levin, Jack Q. Cleveland, Donald F. Marion, Frazier J. Payton, Colquitt Pearson, Ralph S. Sappenfield, Donald W. Smith, Robert T. Spicer, Kenneth Phillips, Arthur H. Weiland, W. Duncan Owens *(Absent—C. Russell Morgan, Jr., Raymond L. Evans)*
DeSOTO - HARDEE - HIGHLANDS - CHARLOTTE-GLADES—Roland W. Banks
DUVAL—Leo M. Wachtel, Jr., Raymond H. King, Raymond R. Killinger, William H. Brooks, Edward Canipelli, John F. Lovejoy, James L. Borland, Karl B. Hanson, John A. Beals, Frank L. Fort, Edward Jelks *(Absent—Charles F. Henley)*
ESCAMBIA—Herbert L. Bryans, Jesse N. McLane, Alvin L. Stebbins
FRANKLIN-GULF—*(No delegate)*
HILLSBOROUGH—Leland F. Carlton, Herschel G. Cole, William G. Meriwether, H. Phillip Hampton, Samuel G. Hibbs, David R. Murphey, Jr., William M. Rowlett
INDIAN RIVER—Erasmus B. Hardee
JACKSON—Courtland D. Whitaker
LAKE—*(Absent—Rabun H. Williams)*
LEE—H. Quillian Jones
LEON - GADSDEN - LIBERTY - WAKULLA - JEFFERSON—George H. Garmany, Taylor W. Griffin
MADISON-SUWANEE—A. Franklin Harrison
MANATEE—Lowrie W. Blake
MARION—Henry L. Harrell
MONROE—*(No delegate)*
NASSAU—John M. McDonald
ORANGE—David Y. Hicks, Jr., Eugene L. Jewett, William S. Mitchell, Chas. J. Collins, Louis M. Orr, II, Duncan T. McEwan
PALM BEACH—Victor Clarholm, Lloyd J. Netto, Frederick K. Herpel, Vale D. Stone
PASCO-HERNANDO-CITRUS—George R. Creekmore
PINELLAS—Francis H. Langley, George H. Anderson, M. Eldridge Black, William M. Davis, John P. Ferrell, William D. Futch, H. Milton Rogers.
POLK—Jere W. Annis, Wiley T. Simpson, Robert J. Jahn
PUTNAM—Grover C. Collins
ST. JOHNS—Hardgrove S. Norris
ST. LUCIE - OKEECHOBEE - MARTIN — *(Absent—Adrian M. Sample)*
SARASOTA—John M. Butcher
SEMINOLE—Frank L. Quillman
TAYLOR—Walter J. Baker
VOLUSIA—Vaughan A. Shaw, Cleland D. Cochrane, Joseph E. Taylor
WALTON-OKALOOSA—Henry C. White, Jr.
WASHINGTON-HOLMES—*(No delegate)*
ASSOCIATION OFFICERS—Joseph S. Stewart, Walter C. Payne, Herbert E. White, Reddin Britt, Robert B. McIver, Shaler Richardson

Report of Reference Committee No. 1

Dr. Edward Jelks, chairman of Reference Committee No. 1, Health and Education, was recognized and asked to present the recommendations of that committee.

Dr. Jelks: "First, I wish to thank the members who spent a busy afternoon of study on the many problems which confronted us."

Dr. Jelks: "Your committee approves the report of the Medical Postgraduate Course Committee with commendation for the splendid work it is doing."

Dr. Jelks moved that this report (printed in Handbook) be adopted with commendation. Motion seconded and carried.

Report of Committee on Medical Postgraduate Course

Turner Z. Cason, *Chairman*

The sixteenth annual Graduate Short Course for doctors of medicine was held in Jacksonville, June 28 to July 3, inclusive, with a total registration of 176 physicians.

Held concurrently with the Short Course was a course in Parasitology and Gastroenterology which had an attendance of 26 physicians and 34 technicians.

A Special Course was held in September at the Duval Medical Center, Jacksonville. This course was by way of a trial project to determine the reaction of the local physicians to a course in which the faculty was composed of Florida physicians. While the attendance by local physicians was poor, it was quite evident that the resident staffs of local hospitals would get much benefit from this type program, which could be taken to each section of the state.

A seminar in Ophthalmology and Otolaryngology was held in Miami Beach from January 10 through January 15 with a total attendance of 150 physicians.

The Committee on Medical Postgraduate Course met at the end of the Short Course in July and again on December 11 when the faculty for the seventeenth annual Short Course was discussed. The date was set for June 20 to June 25, inclusive. Before the decision of location was reached, the committee carefully reviewed the beginning of graduate medicine in Florida, the history of the Short Course in particular, the cities in which the course had been held and the attendance each year, the purpose of the Short Course, those for whom it was to be held, and the accessibility of various locations. The committee seriously and impersonally attempted to determine how and where best to serve the general practitioners, particularly those from the small towns.

After the discussion the committee unanimously agreed:

1. That the purpose of the Short Course was not primarily to serve those physicians in large, populated areas where frequent medical and staff meetings were held, but to serve the nonspecialist living in the smaller cities and towns throughout the state, whether his major interest is surgery, medicine or obstetrics. The committee believes this purpose should always be kept in mind with reference to the Short Course.

2. That because of the strategic location of Jacksonville, and for no other reason, it would be easier for the general practitioner seeking this type of graduate education to attend.

3. That the lecturers and teachers of the same general type and standard of the past few years be continued.

4. That plans be made to offer special graduate courses in the large medical centers.

The committee scheduled a three day seminar on Tuberculosis to be held in Orlando on May 11, 12 and 13.

Also agreed upon were a series of seminars on Clinical Pathology and Laboratory Medicine to be held with the cooperation of the State Board of Health in various cities throughout the state.

The committee approved a proposed special course in Cardiovascular Diseases to be held in Jacksonville this year. The tentative dates for the course were set for June 14 to June 17. It further agreed that this type of course could be effectively held in the larger medical centers where men are specializing either in cardiovascular diseases or in internal medicine.

Approved as proposed were plans for a course in Genitourinary Surgery under the direction of Dr. Robert B. McIver, to be held in Jacksonville, Miami, Orlando, St. Petersburg and Tampa.

A financial statement was presented and approved by the committee. It indicated that the total receipts were $3,325.00, which amount was made up of registration fee receipts amounting to $2,725.00 and an assistance check from the Florida Tuberculosis and Health Association amounting to $600.00. Expenses amounted to a total of $4,131.07, which included $571.98 for faculty expenses paid by the Florida State Board of Health.

The committee was advised that a budget had been submitted to the University of Florida authorities, at their invitation, in which were included the expenses we are now incurring for a part-time secretary, a part-time assistant director, expenses of guest instructors and all miscellaneous expenses. No action was taken by the committee as there had not been any further communication from the University on this subject.

Respectfully submitted,
Turner Z. Cason, *Chairman*

Dr. Jelks: "Your committee requests that the report of the Committee on Cancer Control, as published in the Handbook, be approved, and that the supplemental report be received as information."

Dr. Jelks moved that the report as published in the Handbook be adopted and the supplement be received as information. Motion seconded and carried.

Report of Committee on Cancer Control

Alfred G. Levin, *Chairman*

During the past year the Committee on Cancer Control has continued to serve in its usual advisory and consultant capacity to the Florida Division of the American Cancer Society and the Cancer Division of the State Board of Health. The committee has also pursued the previously established policies of encouraging the creation of more cancer clinics and fostering the widespread dissemination of information concerning cancer through both medical and lay channels.

In its present form, unfortunately, the committee can do little more than make recommendations. We believe that the cancer control program in this state could be greatly strengthened by the formation of a permanent, authoritative Cancer Commission of a type now successfully operating in other parts of the country. It is suggested that the long term programs of such states as Kansas and Connecticut be studied and considered as models worthy of emulation.

An informal gathering of cancer workers, including the directors of most of the tumor clinics throughout the state, representatives from the American Cancer Society, state and county health officers, officials of the Florida Medical Association and other interested individuals, was held in Tampa on July 16. This meeting was jointly sponsored by the Committee on Cancer Control and the State Board of Health. Its primary function was to discuss clarification and simplification of the rules and regulations of the State Cancer Control Program as provided for in Legislative Bill No. 384 passed in 1947. There was active discussion of several controversial issues, particularly those concerned with the most efficacious use of the limited funds available. It was generally agreed that we should support the State Board of Health's contention that first consideration be given to those cancer cases in which there is a reasonable chance for cure. There was also general acceptance of the policy of routing patients through approved cancer clinics. It was agreed that the annual appropriation of $200,000 be increased to $500,000 if possible. A practically verbatim report of the proceedings is available through the office of Dr. Roger F. Sondag in Jacksonville. A particularly gratifying result of this meeting was the establishment of a warm feeling of understanding and cooperation between the practicing physicians and the personnel of the State Board of Health.

Two official meetings of the Committee on Cancer Control were held during the year and among actions taken were the following:

1. A mobile cancer unit project of the State Board of Health was approved.

2. The principal of payment of fees by examinees going through Detection Centers was approved.

3. The policy of referring positive or suspicious cases from detection centers back to the referring or family physician or to the closest approved cancer clinic was approved.

4. The distribution of simple cancer pamphlets to all physicians and the presentation of cancer programs in smaller communities were recommended.

5. The establishment of tumor boards in hospitals and the presentation of all controversial cases to such boards or to entire clinic groups were recommended.

6. A recommendation was made to the State Board of Health that a hospital for terminal care of cancer cases be established in Florida.

7. It was suggested that for the sake of "harmonious cooperation" the Committee on Cancer Control be represented on the Board of Directors and the Executive Committee of the American Cancer Society, Florida Division, Inc.

8. It was suggested that the Committee on Cancer Control act in liaison capacity between the American Cancer Society and local medical groups.

The annual Southeastern Cancer Seminar which is financed jointly by the State Board of Health and the American Cancer Society was successfully held in Tampa in November, 1948 under the direction of the Tampa Tumor Clinic. The 1949 session will be held in Miami with the Dade County Medical Association acting as host. A program of unusual interest and value is promised.

The cancer control program in Florida is still in an early, formative stage and a great deal of diligent work must be done if the ultimate goal of significantly reducing cancer morbidity and mortality is to be reached.

Respectfully submitted,
Alfred G. Levin, *Chairman*

Dr. Jelks: "We recommend the approval of the report of the Committee on Venereal Disease Control, as published in the Handbook, and I move that it be adopted."

Motion seconded and carried.

Report of Committee on Venereal Disease Control

Jack A. McKenzie, *Chairman*

In June 1948, Dr. Roger F. Sondag, director of the Bureau of Preventable Diseases, Florida State Board of Health, met in Miami with two members of the Committee on Venereal Disease Control. At that time, Dr. Sondag outlined for us the plans for control of venereal disease. The plan includes an educational program through the medium of movies and literature and free distribution of penicillin to the doctors for every reported case of gonorrhea. Through this plan there was hope of getting these patients into the hands of private practitioners. In spite of these efforts, the program has not gone too well. In the larger cities, the private physicians did not want to be bothered with indigent or semi-indigent patients and believed the clinic should take care of them. In the smaller communities the private physicians have accepted the program.

There has been very little change in the statistics of reported cases except that there have been more cases of granuloma inguinale treated at the Rapid Treatment Center. Streptomycin has been made available for the treatment of these patients. The response has been excellent; some were cured who had had the disease for as long as twenty years.

During 1948, as in the past, the importance of finding venereal disease cases early, removing patients from circulation and getting them under medical supervision has been stressed.

There has been no great increase in venereal disease during 1948 as compared to 1947. There was a slight increase in primary and secondary syphilis, but this increase was not significant.

Respectfully submitted,
Jack A. McKenzie, *Chairman*

Dr. Jelks: "The report of the Committee on Tuberculosis and Public Health is approved with the deletion of paragraph three as published in the Handbook."

Dr. Jelks moved that the report be approved with deletion. Motion seconded and carried.

Report of Committee on Tuberculosis and Public Health

Alvin L. Stebbins, *Chairman*

Although no formal meeting of this committee has been called during the year, the necessary business was carried on through correspondence.

The chairman, or a member of the committee, has attended several meetings of the Florida Tuberculosis and Health Association in an advisory capacity. At one of these meetings, a preliminary report of the field survey made by the National Tuberculosis Association was heard. Complimentary remarks were made on the good work being done in Florida. At another meeting there was discussion concerning ways and means of handling recalcitrant patients and increasing funds to aid the families of tuberculous patients.

Respectfully submitted,
Alvin L. Stebbins, *Chairman*

Dr. Jelks: "We recommend approval of the report of the Committee on Maternal Welfare, as read at First Meeting of the House."

A request was made that the report be again read, which was done.

Dr. Jelks moved that the report be adopted. Motion seconded and carried.

Report of Committee on Maternal Welfare

Harold G. Nix, *Chairman*

The Committee on Maternal Welfare has studied problem of maternal deaths in the State of Florida and as a result, submits the following recommendation.

The State of Florida ranks forty-sixth in the nation in maternal deaths. There is no functional program in operation to study this problem in relation to preventable and non-preventable death.

Therefore, it is recommended that the Committee on Maternal Welfare be authorized to promote this study in cooperation with the Bureau of Maternal Health of the Florida State Board of Health.

Respectfully submitted,
Harold G. Nix, *Chairman*

Dr. Jelks: "Your committee recommends the approval of the report of the Committee on Child Health, as published in the Handbook, and I move that this report be adopted."

Motion seconded and carried.

Report of Committee on Child Health

Warren W. Quillian, *Chairman*

An effort has been made during the past year to cooperate actively with existing organizations in the field of child health. Specifically, the Committee on Child Health has assisted in editing a manual prepared under the capable leadership of Mrs. Roberta M. Yoakley, consultant for the education of exceptional children, with the State Department of Education. Individually, the members of the group have participated in the plans for the improvement of child health sponsored by the Florida Study of Child Health Services. Authentic information pertaining to the care received by infants and children in Florida was accumulated as a part of the nationwide study made by the American Academy of Pediatrics, and the material has been studied with the idea of making long range plans for improvement. This involves better preparation of physicians for the problems of child care, and the development of extension programs which will make it possible for children in isolated areas to receive the same opportunities for good care that are available near large medical centers. Much credit is due

Dr. George L. Cook of Tampa, state chairman of the Academy of Pediatrics, who has been indefatigable in compilation of data and in pointing out constructively the needs for better child care in this state. In the face of discouraging problems, much has been accomplished. The State Board of Health, the State Department of Education and the voluntary agencies for child care have been very cooperative in this work. A definite proposal will be made to the Florida State Pediatric Association at the spring meeting for implementing some of the recommendations of Dr. Cook and his committee with reference to child health in Florida.

Many organizations are interested in the improvement of child health. Your committee suggests that a Children's Council be formed by the Florida Medical Association in an attempt to integrate the manifold efforts now being put forth in this field. Membership might well include representatives from the Florida State Pediatric Association, the American Academy of Pediatrics, Florida Dental Society, State Board of Health, State Department of Education and also representatives from the civic groups, such as Rotary, Kiwanis, the American Legion, the Parent-Teacher organizations and so forth. Several of these organizations already have committees concerned with the problems of child care and would be eager for guidance and leadership in the formulation of an overall program for the betterment of child health in this state. Detailed procedures might well be outlined by such a Children's Council. Improvement in hospital facilities, better care for premature infants, and more alert supervision of well children will inevitably result from a more widespread interest.

There is a close relationship between the committee and the Florida State Pediatric Association. The membership is being consulted whenever pediatric problems arise, and several of the men are participating actively in various lay and professional organizations in the state which are concerned with child health problems. Private medicine is being challenged as never before to assure that medical services of high quality are available to all children. The doctors who give the care should undertake a greater responsibility in planning for the improvement of child health.

Respectfully submitted,
Warren W. Quillian, *Chairman*

Dr. Jelks: "Your committee approves the report of the Committee on Conservation of Vision, as published in the Handbook."

Dr. Jelks moved that the report be adopted. Motion seconded and carried.

Report of Committee on Conservation of Vision

Nathan S. Rubin, *Chairman*

The Committee on Conservation of Vision has not been called upon to hold any official meetings during the past year. Such activities as were necessary have been consummated through correspondence.

The committee acknowledges the fine achievement of the Florida Council for the Blind, of the State Welfare Board, and of the Florida Vocational Rehabilitation Service in locating and attending to great numbers of persons throughout the state who have visual disabilities. In this work, a considerable amount of accurate medical information has been recorded during the past ten years that can form a valuable body of data on the causes of blindness in Florida and can lay the foundation for a state program of sight conservation. These data deserve the immediate attention of the Medical Advisory Committee of the Florida Council for the Blind or of the Ophthalmologic Consultants of the various agencies who have the data in hand. An analysis of these statistics can then give substance to an effective statewide sight conservation program.

Present sight conservation programs are not reaching into the remote parts of the state probably because of difficulties in providing eye examinations in rural and sparsely populated areas. Special effort should be made to extend to persons in the small communities the benefit of programs of assistance and service to the visually handicapped, including eye examinations, refractions, and minor treatments and operations, possibly through a mobile eye unit under auspices of the Florida Council for the Blind.

Clinical services to provide specialized eye care for the indigent, like that recently established in the Escambia General Hospital in Pensacola, should be established in all large centers of population throughout the state. The indigent, because of their poverty, are particularly susceptible to disabling eye conditions. Provision should also be made for specialized care of indigent persons who are not yet in a state of economic blindness but who have eye conditions which, if not arrested, may result in progressive loss of vision.

Programs of health education of the public, especially in regard to venereal disease and tuberculosis control, disseminated through general public health nurses, school teachers, social workers and others, have a definite place in any sight conservation program. Safety education of parents and children through Safety Councils can show the danger in play or sport when it involves eye hazards such as sharp pointed objects or explosives. There is a great need to stimulate an awareness of the early signs and symptoms of glaucoma and to spread the information that early detection and sustained treatment is necessary to avoid this widely prevalent cause of blindness. Industrial eye accidents and their prevention are the concern of the safety engineer, management and the workman, but also merit the attention and help of the ophthalmologist in any well rounded program of sight conservation.

Although eye health problems of school children are primarily the responsibility of the parents and of the school authorities, the ophthalmologist should share that responsibility by advising in regard to what is a correct school environment and by helping to educate teachers, parents and children in their responsibilities. Visual screening programs in the schools by carefully selected and prepared personnel who use standardized procedures and equipment for testing can aid in early diagnosis and care of eye difficulties in children. The patient and his family should be encouraged and guided in carrying out any recommendations and arranging for such help and supervision as may be needed. It should be the responsibility of the school system to provide special services and educational media (sight saving classes) for children who are not blind but have serious impairment of vision that can be expected to progress. Blind children with eye conditions for which surgical care is indicated should come within the scope of the State Crippled Children's program.

It is also most advisable to alert the general practitioner to the early diagnosis of conditions involving sight, like glaucoma and strabismus. Exhibits should be on display at the annual meetings, and the program chairman of each component county medical society in the state should be urged to include at least one sight conservation program to which a qualified ophthalmologist shall be invited to discuss conditions such as glaucoma, the early treatment of strabismus and the prevention of eye injuries.

Respectfully submitted,
Nathan S. Rubin, *Chairman*

Dr. Jelks: "Your committee had for consideration a resolution concerning the use of special containers for poisons. We recommend the approval of this resolution, except for the sixth paragraph. Your committee recommends that this paragraph be changed to read:

BE IT FURTHER RESOLVED that it is respectfully suggested that appropriate recognition be given Mrs. Nell H. Durrance for advancing an

idea which should result in the saving of human lives."

Dr. Jelks moved the adoption of the resolution as amended. Motion seconded and carried.

Resolution

Whereas, hundreds of deaths and much unnecessary illness are caused each year through the accidental and careless use of poison, and

Whereas, Mrs. Nell H. Durrance, a registered nurse of Sebring, Florida, has advanced the idea that many of such deaths could be avoided by using rough-surface glass containers for liquid poison and rough-surface cardboard containers for powdered and solid poison, and

Whereas, it appears that the enactment of State and Federal laws requiring the use of such containers for poison would serve as a great safeguard against accidental deaths by poison, and

Whereas, the DeSoto - Hardee - Highlands - Charlotte-Glades Medical Society has recommended the enactment of such legislation,

Now, Therefore, Be It Resolved by the Florida Medical Association in open session that the Legislature of the State of Florida and the Congress of the United States of America are hereby urged to enact suitable legislation requiring, in addition to the labels now required by law, the use of containers for poison that are instantly distinguishable by human touch.

Be It Further Resolved that it is respectfully suggested that appropriate recognition be given Mrs. Nell H. Durrance for advancing an idea which should result in the saving of human lives.

Be It Further Resolved that a copy of this resolution be promptly mailed to each United States Senator and Member of Congress from Florida, the President of the Florida Senate, the Speaker of the Florida House of Representatives, The American Medical Association, the Federal Security Administrator, Washington, D. C., and Florida State Board of Health.

Dr. Jelks: "Your committee had for consideration a resolution relative to the teaching of anatomy and physiology. We approve fully the resolution except for the word 'compulsory' in the last paragraph."

Dr. Jelks moved the resolution be adopted as amended. Motion seconded and carried.

Resolution

At a regular monthly meeting of the Volusia County Medical Society in January 1949, our delegates were instructed to present the following resolution before the House of Delegates of the Florida Medical Association at the 1949 state convention.

Whereas, the public is not sufficiently well informed about the function and structure of the human body to develop proper health and sanitary practices.

Whereas, current trends of health education about disease processes are often poorly understood or misinterpreted by the public due in part to a lack of basic information about the human body.

Whereas, there is no uniformity of instruction in our public schools on human physiology and anatomy.

Whereas, the Florida Medical Association as a part of the American Medical Association has an inherent responsibility to discharge in all health matters affecting the public.

Therefore Be It Resolved by the House of Delegates of the Florida Medical Association:

That said Association instruct the Florida Academy of Public Medicine to make its service and assistance available, and to officially urge the State Board of Education to establish a well integrated course of instruction on the physiology and anatomy of the human body. That such instruction begin as early as practicable in elementary schools and extend through college.

Dr. Jelks: "Your committee had for consideration a resolution concerning the practice of naturopathy and would like to recommend approval of a substitute resolution for the one Dr. Bryans presented."

Discussion by Dr. Walter E. Murphree and Dr. Herbert L. Bryans followed.

Dr. Murphree moved that the paragraph read by Dr. Bryans be included and the substitute resolution then be approved as amended.

Motion seconded and carried.

Resolution

Whereas, the Board has information which indicates that the practice of Naturopathy includes the licensing of naturopathic physicians and the treatment of patients of licensed naturopathic physicians is being conducted in such a manner as to be detrimental to the public health of Florida, and

Whereas, on the 12th of April, 1949, Senator Beale of Escambia County introduced into the Florida Senate a bill designated as Senate Bill 109, abolishing existing statutes regarding the practice of naturopathy,

Therefore Be It Resolved that the Florida Medical Association approve the passage of Senate Bill 109.

Be It Further Resolved that a copy of this resolution be forwarded to the Governor of the State of Florida and to all members of the Florida Senate and the Florida House of Representatives.

Dr. Jelks: "Your committee approves the resolution concerning the Florida Committee on Fetus and the Newborn."

Dr. Jelks moved that this resolution be adopted. Motion seconded and carried.

Resolution Approving the Florida Committee on Fetus and Newborn

Whereas there has been formed recently a State Committee on Fetus and Newborn, in cooperation with the American Academy of Pediatrics Committee on Fetus and Newborn, the Florida State Pediatric Association, the Florida Obstetric and Gynecologic Society, and the Division of Child and Maternal Welfare of the State Board of Health, whose aim is the improvement of the care of newborn infants especially in the newborn nurseries of Florida hospitals, Be It Resolved That (1) The Florida Medical Association go on record approving the said committee and (2) that the President be requested to appoint a representative of this Association to serve on the Florida Committee on Fetus and Newborn.

The Chair requested the president-elect to carry out item two in the above resolution.

Dr. Jelks: "Your committee had for consideration a resolution concerning the practice of medical technologists."

Recommendation On Medical Technologists Resolution

Dr. Jelks: "Your committee recommends that this resolution be *not* approved." *("not" deleted later)*

"It further recommends and urges the Florida Medical Association to cooperate with the Florida Society of Medical Technologists in their efforts

to raise the standards of qualifications for their members and suggests that the Florida Society of Medical Technologists cooperate further with the Florida Pathological Society, the Florida State Board of Health and the Florida Division of the American Society of Medical Technologists in working out plans whereby the Technologists may render better service."

A general discussion followed.

Dr. Flipse: "I arise to recommend that the word 'not' be stricken from the first sentence of the above recommendation making it read: 'Your committee recommends that this resolution be approved.' "

Seconded.

Dr. Murphey: "I request that the courtesy of the floor be extended to Dr. Gretchen V. Squires."

The Chair recognized Dr. Squires.

Also recognized for discussion were Drs. M. Jay Flipse, Jack Q. Cleveland, Kenneth Phillips and William M. Rowlett.

Dr. Rowlett: "I move that the entire matter to commit be referred to the Board of Governors with power to act."

Seconded.

Dr. Flipse amended Dr. Rowlett's motion to commit by adding "and that their recommendation be made known to the advisory committee of our advisory to the Executive Committee of Florida Society of Medical Technologists with recommendations that the Florida Society of Medical Technologists accept the conclusions of the deliberations of the Board of Governors of the Florida Medical Association as the opinion of the Florida Medical Association."

Discussion by Dr. McEwan.

The Chair put the motion to commit and it was lost.

The Chair: "Your reference committee recommended that this resolution be not approved. Dr. Flipse amended to strike out the word 'not', and that the resolution be approved. If you are in favor of Dr. Jelks' recommendation to retain the word 'not', vote 'yes'; if you are against it, vote 'no'."

On a standing vote the Chair announced 40 in favor and 45 against.

Dr. Jelks moved the adoption of the recommendation with the word "not" deleted. Motion seconded and carried.

Resolution

WHEREAS, the medical profession is dependent upon clinical laboratories for accurate laboratory studies in the care of private patients, and

WHEREAS, there is at present no inspection nor supervision exercised over the private clinical laboratories in the State of Florida, and

WHEREAS, the better qualified medical technologists recognize the necessity of maintaining high standards in their work for the benefit of the medical profession and the general public, and

WHEREAS, The Florida Society of Medical Technologists in an attempt to improve the standards of their profession have proposed the creation of a State Board of Examiners to examine individuals working in or directing private laboratories for medical technology, and

WHEREAS, The Florida Society of Medical Technologists in proposing these regulations to correct the present uncontrolled operation of private clinical laboratories, has acted with the advice of Committees appointed by the president of the Florida Medical Association, therefore

BE IT RESOLVED, by the House of Delegates of the Florida Medical Association that the efforts of the Florida Society of Medical Technologists to establish a State Board of Examiners be commended and approved in principle, and furthermore

BE IT RESOLVED, that this resolution be spread upon the minutes of this meeting of the House of Delegates of the Florida Medical Association and that copies be furnished to the Florida Society of Medical Technologists and interested organizations or individuals.

Dr. Jelks announced that this completes the report of Reference Committee No. 1, Health and Education.

Report of Reference Committee No. 2

Dr. H. Quillian Jones, chairman of Reference Committee No. 2, Public Policy, was recognized and asked to present the recommendations of that committee.

Dr. Jones: "Your committee has considered the resolution by Dr. Leigh F. Robinson concerning the instructing of Delegates to the A. M. A. in regards to the Blue Shield Commission's place in the A. M. A. Public Relations Program. We approve this resolution in principle with the recommendation that it be published."

Dr. Jones moved that the resolution be approved in principle but that it be further edited for clarification before it is presented to the A. M. A.

Seconded. Motion carried.

Dr. Pearson: "Are we to present a resolution or give support to a resolution of like manner? Do we want to present a resolution ourselves?"

Dr. Jones advised that this resolution was just adopted in principle and it would be edited for clarification before presenting to the A. M. A.

Discussion by Dr. Leigh F. Robinson.

Dr. Pearson: "You want the resolution presented as you presented it here?"

Dr. Robinson: "Yes, the House of Delegates wishes to make just one recommendation. It will be satisfactory."

A Resolution Instructing Delegates to the American Medical Association in Regards to the Blue Shield Commission's Place in the American Medical Association's Public Relations Program

Whereas, the American Medical Association is vigorously promoting the highest standards of medical care and in explanation thereof is organizing a great public relations program; and

Whereas, this program known as the American Medical Association 12 Point Program is dependent on the full cooperation of state and county component medical societies of the American Medical Association; and

Whereas, of the 48 state component societies 38 have sponsored and organized in their respective states non-profit medical care plans; and

Whereas, these medical care plans associated themselves together two and one-half years ago incorporating under the name of Associated Medical Care Plans; and

Whereas, said Associated Medical Care Plans adopted a Blue Shield with a caduceus on its face as its insignia and later formed a committee from its body to be known as the Blue Shield Commission; and

Whereas, the object of said Blue Shield Commission was to correlate the work between the Council of Medical Care of the American Medical Association and the work of the Blue Cross Commission of the American Hospital Association; and

Whereas, the Associated Medical Care Plans and the Blue Shield Commission have grown in the past two and one-half years from an organization of 9 medical care plans giving voluntary health protection to less than 3,000,000 people to an association of 58 plans giving voluntary health protection to over 10,000,000 people; and

Whereas, the success of these 58 plans stands in eloquent appeal to the public as to the potentialities of Voluntary Health Insurance as compared to Compulsory Health Insurance; and

Whereas, Voluntary Health Insurance is so rapidly being accepted by the public and meeting the medical care problems that scores of congressional leaders who formerly were inclined to support compulsory health legislation are now convinced that Voluntary Health Insurance as offered the public through the many plans of the Associated Medical Care Plans should be given a thorough trial before passing any compulsory health legislation; and

Whereas, these facts have also impressed the public of the important role that the medical profession has played in developing these Blue Shield Plans throughout the nation; and

Whereas, the Blue Shield Commission, the executive body of the Associated Medical Care Plans, finds itself being held responsible by a majority of the state medical plans for further development of voluntary health insurance in order that the needs of the public can be met not only on a local but also on a national scale; and

Whereas, it would seem the American Medical Association in appointing members to the Council of Medical Service has overlooked the importance of making such appointments from those medical men throughout the many states who have studied and worked in their state medical associations toward building up voluntary health plans with the result that the present membership of the Council of Medical Service of the American Medical Association is made up of men with little practical experience with voluntary health plans; and

Whereas, the American Medical Association through its Council of Medical Service as constituted has shown no evidence that the Associated Medical Care Plans has any place in her Public Relations Program; and

Whereas, this position of the American Medical Association is producing a definite and dangerous rift between the American Medical Association and Associated Medical Care Plans; and

Whereas, this rift unless checked may spread to the State Medical Associations who have sponsored through the State Blue Shield Plans the Associated Medical Care Plans; and

Whereas, all of these facts from the formation of the first medical care plan to the present when a whole nation is looking to the medical profession for proof that medical needs can be met by voluntary health insurance, the Medical Profession in general, and the American Medical Association in particular, must recognize that the many non-profit medical care plans throughout the United States as organized under the Associated Medical Care Plans is the essential element of the American Medical Association's Public Relations Program, and without these health plans so well organized by State Medical Associations, the American Medical Association has no other major solution of the problems of nationwide medical care to offer the public: Therefore, Be It

Resolved, that the House of Delegates of the Florida Medical Association go on record in commending the Associated Medical Care Plans and the Blue Shield Commission for their outstanding work and material progress in non-profit Voluntary Health Insurance; and Be It Further

Resolved, that the Delegates to the American Medical Association from the Florida Medical Association be instructed to offer a resolution and, or, support any measure that will affect an understanding in the Council of Medical Service of the American Medical Association of the absolute importance that the Associated Medical Care Plans, must play in its public relations campaign.

Dr. Jones: "Your committee recommends approval of the resolution concerning a national service plan as proposed by the Blue Shield Commission. The committee approves this resolution as presented by the Blue Shield Commission with a penciled notation by Dr. Netto, amending as follows: 'and provided that the Constitution and By-Laws of such National Service Plan shall be ratified by this House of Delegates and/or the Board of Governors of the Florida Medical Association.'"

Seconded. Motion carried.

A Resolution Supporting the Proposal for a National Medical Service Plan As Proposed by the Blue Shield Commission

Whereas, Voluntary Non-Profit Health Insurance as offered the public through the many State and County Blue Shield Plans is the essential element in the Public Relations Program of the American Medical Association; and

Whereas, the giant employer groups of the nation such as American Telephone and Telegraph, Ford Motor Company, etc., have been at a disadvantage in offering Blue Shield coverage to their employees because all such plans are local and have many different types of coverage; and

Whereas, the Blue Shield Commission on January 15, 1949, proposed a national insurance corporation to operate as a national Blue Shield enrollment agency to supplement the work of the many State Blue Shield plans in order that the large national employee groups can be offered non-profit voluntary health insurance on a national basis; and

Whereas, at the same time the Blue Shield Commission voted to cooperate with the Blue Cross which now is in the process of setting up a National Blue Cross and has offered to cooperate with the Blue Shield in joint administration of the two Plans; and

Whereas, a true approval of organized medicine can best be obtained through a vote of the many state medical associations who have sponsored and built up the 58 non-profit voluntary health plans; Therefore Be It

Resolven, That the House of Delegates of the Florida Medical Association approve the proposed program of the

Blue Shield Commission to organize a National Medical Service Plan to be operated jointly with the National Hospital Plan of Blue Cross, provided the corporated body of the plan provides that a majority of its Board of Directors be composed of doctors of medicine and that no member of the Board of Directors be a salaried employee of any state or national government or of any insurance company or health plan, and provided that the Constitution and By-Laws of such National Service Plan shall be ratified by this House of Delegates and/or the Board of Governors of the Florida Medical Association: BE IT FURTHER

RESOLVED, That copies of this resolution be mailed to every state medical society with a letter of transmittal urging all state societies to join the Florida Medical Association in approving as soon as possible the Blue Shield proposal to set up a National Blue Shield Plan.

Dr. Jones: "Your committee had for consideration a resolution concerning State Board of Health Inspection of Eating Places, and recommends that this resolution be adopted with the following addition: 'Since very few legislators read medical news that a copy of this resolution be sent to each of our legislators.' "

Dr. Jones moved the adoption of the resolution as amended.

Seconded. Motion carried.

It was announced from the floor that the bill to which this resolution has reference has already passed one House, so it was urged that this be marked "rush".

Resolution

WHEREAS, it has been noted in a recent press release that a bill was introduced in the House whereby the State Board of Health would release thirty sanitary inspectors with a saving of $120,000.00 and the Florida Hotel Commission would have the sole responsibility of hotel and restaurant inspections.

WHEREAS, the State Board of Health has no inspectors in the field, however the City and County Health Units do have trained and qualified men. These inspectors in the County Health Unit have the assistance of specially trained men in medicine, sanitary engineering, bacteriology, and others.

WHEREAS, Florida has gone further in efficiency and economy of work through its County Health Units than practically any other state of the union. The County health units represent the pooled efforts and resources of municipalities, school boards, medical societies, counties, State, Federal Government, voluntary health associations and in some cases private industries.

WHEREAS, most of these inspection services are paid for by local bodies such as cities and counties. The proposed saving in State funds would not result in reduction of sanitary inspectors but in other fields of service because many city ordinances require such inspections by local health departments under long standing agreements.

WHEREAS, the responsibility for the public's health was placed upon the State Board of Health by the State Constitution.

THEREFORE, BE IT RESOLVED that the Florida Medical Association go on record as being opposed to any change in the existing method of inspection of public eating establishments, and that the services be continued under the State Board of Health and the County Health Units. Since very few legislators read medical news that a copy of this resolution be sent to each of our legislators.

Dr. Jones: "Your committee recommends that the resolution concerning Industrial Fee Schedules be withdrawn and not published."

Dr. Jones moved that the recommendation of the committee be approved to withdraw.

Seconded. Motion carried.

Dr. Jones moved that the report of the Committee on Medical Education and Hospitals, as published in the Handbook, be adopted.

Seconded. Motion carried.

Report of Committee on Medical Education and Hospitals

Thomas C. Kenaston, *Chairman*

In the report of this committee for 1948, attention was called to the minimum requirement of additional beds for all types of hospitals in this state. The survey conducted under the Federal Survey and Construction Act had shown a need for 15,087 additional beds. We are informed by the Florida State Improvement Commission, Hospital Division, that they now have nine projects under construction representing a building program of over $10,000,000 and expect to soon have fourteen projects under construction totaling approximately $14,000,000. This program will supply 1,203 beds.

The Florida Hospital Association, meeting at Orlando on Nov. 19 and 20, 1948, requested in a resolution the 1949 Florida legislature to memorialize and petition the 81st Congress of the United States to make up for the lack of an appropriation for the first year of the five year program of the Federal Hospital Survey and Construction Act, Public Law No. 725, by giving to the Surgeon General of the United States Public Health Service contractural obligation authority for $150,000,000 for the fiscal year 1949-1950, and continuing this contractural obligation authority at the rate of $150,000,000 annually until the state will have met a much larger proportion of hospital and health center needs than is possible under the presently authorized annual appropriation. It is the opinion of this committee that the Florida Hospital Association should have our commendation and endorsement of their resolution.

In October, 1948 this committee was delegated by our president to act as a Committee on Emergency Medical Service in conjunction with the Council on Emergency Medical Service of the American Medical Association. This council conceives its general purpose to be:

> "The development of proper, logical and timely advice for presentation to the Board of Trustees of the American Medical Association with reference to the medical and associated problems involved in the mobilization of the nation's armed forces, industry, agriculture and civilian population in time of national emergency."

Considerable study has been given to formulating a disaster plan for the state in connection with the program of the Council on Emergency Medical Service. One of your committee attended a course sponsored by the United States Navy on "Medical Aspects of Atomic Warfare and Medical Isotopes," which was conducted at the Navy Medical Center, Bethesda, Md. A bill is being drawn up, patterned after the recommendations of the Office of Civilian Defense, to be known as the Florida Civil Defense Act of 1949. This bill when completed, if approved by the other committees concerned and by the Board of Governors, will be presented in the Florida legislature under the sponsorship of the medical profession. A further report in this regard should be available at the annual meeting of this Association.

Respectfully submitted,
Thomas C. Kenaston, *Chairman*

Dr. Jones read the supplemental report of the Committee on Necrology. All persons present stood for a moment in reverence and respect for the departed colleagues.

Dr. Jones moved that the report of the Committee on Necrology, as published in the Handbook, and the supplemental report be approved.

Seconded and carried.

Report of Committee on Necrology

Reddin Britt, *Chairman*

During the last fiscal year our Association lost by death the members whose names are listed below:

Leonard A. Baker, Miami
William H. Bradford, Chevy Chase, Md.
William J. Buck, Belle Glade
Bruce F. Butler, Hollywood
Haynsworth D. Clark, Ft. Pierce
Henry C. Dozier, Lavallette, N. J.
G. LeRoy Edwards, Sarasota
Francis B. Enneis, Jacksonville
Perry C. Farnell, Branford
Clifford J. Gay, Jacksonville
Frank L. Hall, Grand Isle, Vt.
Frank L. Keeler, Miami
Frederick W. Krueger, Jacksonville
Edw. Meadow, Miami
James R. Norton, Port St. Joe
Geo. C. Overstreet, Lakeland
John D. Peabody, Asheville, N. C.
James H. Pittman, West Palm Beach
Samuel Puleston, Sanford
James E. Rawlings, Black Mountain, N. C.
John L. Redding, Orlando
Lawrence Simcox, St. Petersburg
James W. Smith, Miami
F. Leslie Snyder, Jr., Ft. Lauderdale
Ben D. Spears, Wauchula
Lawrence L. Stepp, Ft. Lauderdale
Noble A. Upchurch, Jacksonville
Arthur W. Wood, Miami

Supplement

George L. Cook, Tampa
Orville H. Cribbins, Sarasota
Harold A. Ryan, Miami Beach
Hobart E. Warren, Palm Beach
Roland T. White, Orlando

When possible, obituaries have appeared in The Journal relative to the deaths of these doctors. Tributes have been paid to them in the different communities where they have practiced.

May we at this time stand for a moment of silence in reverence and respect to the memory of our departed colleagues.

Respectfully submitted,
Reddin Britt, *Chairman*

Dr. Jones moved that the report of the Committee on Medical Economics, as published in the Handbook, be approved and that in reference to paragraph three of the report that the Committee on Medical Economics be directed by the incoming president to carry out an immediate comprehensive study of all existing fee schedules, or that a committee be appointed to carry out such study.

Seconded with addition. Motion carried.

Report of Committee on Medical Economics

John D. Milton, *Chairman*

Your committee, according to the resolutions of the Escambia County Medical Society, during the past ten months has studied the fee schedules of many organizations. I can assure you that this is no little task as some of the schedules are so far apart, as far apart as Shanghai is from Boston. Please let me report that the Committee on Medical Economics and the Fee Schedule Committee of the Florida Association of Industrial and Railway Surgeons have revamped the entire fee schedule of the Industrial Commission and have an appointment with Mr. Walter Rountree, director of the Industrial Commission, State of Florida, in the early part of February. We endeavored to have this meeting in January, but this could not be arranged. Therefore, the final report of this particular meeting will have to be given to the Association verbally at the annual meeting. A copy of the proposed changes and new figures is herewith attached.

Due to the fact that there are so many committees working on so many different fee schedules, I feel it would be advantageous to the entire Florida Medical Association, that one committee should be appointed to cover the fee schedules for all the different organizations in the state of Florida, such as Industrial Commission, Veterans Administration, Blue Cross and Blue Shield, Rehabilitation Vocational Training, Association for Industrial and Railway Surgeons, Florida Council for the Blind and Florida Crippled Children's Commission.

After studying the fee schedules and seeing that there should be some definite changes, such a committee should coordinate with the proper parties relative to such changes. In this manner there will be unification of effort and not everyone working in the dark as to what the other party might be doing.

If there ever was a time that demands a unification of effort, it is at present when we are confronted with a possibility of socialized medicine. We believe that the question of socialized medicine is somewhat under the Committee on Medical Economics, but here again other committees are acting on this and leaving the Committee on Medical Economics in the dark. Therefore, the Committee on Medical Economics assumed a "hands off" policy on this particular question, because everybody's business is nobody's business.

We make these remarks not in the destructive manner but purely in a constructive way of thinking.

Respectfully submitted,
John D. Milton, *Chairman*

Dr. Jones moved that the report of the Committee on Interrelationship, as published in the Handbook, be adopted.

Seconded. Motion carried.

Report of Committee on Interrelationship

Henry J. Peavy, *Chairman*

The Committee on Interrelationship, as in the past, has kept in touch with the Bureau of Professional Relations of the School of Pharmacy of the University of Florida. We have had considerable correspondence with Dr. P. A. Foote, director, and several consultations with Mr. L. W. Harrell, assistant director. The work of the bureau is increasing and is being carried on most efficiently by Dr. Foote and Mr. Harrell.

Last year the Florida Dental Society appointed a special committee on medical dental relations with Jesse L Williams, D.D.S., of Jacksonville, chairman. After considerable correspondence with Dr. Williams, a meeting was held with members of both committees and the following recommendations were made:

1. Closer cooperation of the medical, dental, and pharmaceutical professions in order to safeguard public welfare as well as our own interests.

2. Closer cooperation of these professions in their professional work.

3. Invitations extended to such seminars or postgraduate courses that would prove interesting and helpful to the other professions.

4. Encourage the inclusion of dental services on hospital staffs and require attendance at hospital staff meetings.

At the invitation of Dr. Williams, your chairman attended the Hollywood meeting of the Florida Dental Society. Dr. Williams is an enthusiastic and energetic worker and has offered a resolution that the Florida Dental Society make its Interrelationship Committee a permanent committee. We are greatly pleased at this interest, and in the future we hope all our allied professions will appoint Interrelationship Committees so that it will encourage closer cooperation.

Respectfully submitted,
Henry J. Peavy, *Chairman*

Dr. Jones moved that the report of the Committee on State Controlled Medical Institutions, as published in the Handbook, be approved.

Seconded. Motion carried.

Report of Committee on State Controlled Medical Institutions

Lloyd J. Netto, *Chairman*

It is surprising that this important subject is so little known of by our Association and even by the State Administration. The following is a quotation of the first paragraph in the reply to me from the Honorable R. A. Gray, Secretary of State: "Replying to yours of the twentieth I do not know of any 'State Controlled Medical Institutions.' It may be that you have in mind such an institution as the Florida State Hospital for the Insane. The Florida Farm Colony for Epileptics and Feeble Minded at Gainesville is a smaller similar institution."

Having eventually obtained the desired information, I intended to make a personal visit to each of these institutions. I had counted heavily on doing this so that I may have made a direct firsthand report to the House of Delegates for my committee. Circumstances beyond my control caused me to give up this idea so that I am herewith submitting my report on the basis of correspondence with the three most important state controlled medical institutions; namely: Florida State Prison at Raiford; Florida Farm Colony at Gainesville; and the Florida State Hospital for the Insane at Chattahoochee.

The most immediate need of the Florida State Prison, expressed to me by Mr. L. F. Chapman, superintendent, is that of a new tuberculosis ward. They now have forty-seven patients in this institution suffering from tuberculosis; and while they are segregated, the quarters are utterly inadequate. A second need is that of an assistant prison physician.

The Florida Farm Colony at Gainesville now has a full time resident physician, Dr. Alexander D. Gordon, commissioned in November, 1948. Correspondence with Mr. C. R. Phillips, superintendent, informs me that Dr. Gordon is doing a splendid job. The building program for this institution has been approved by the proper committees. The budget was cut to some extent, but not drastically. We hope that the Florida legislature will confirm the building program and the budget, the latter of which includes provisions for much-needed additional equipment at the hospital. In the words of the superintendent, this institution is apparently being well cared for, and at the present time has no real pressing medical need.

Dr. J. H. Therrell, superintendent of Florida State Hospital at Chattahoochee, informs me that the first and foremost need is an addition to the general hospital, which the Budget Commission has just recently seen fit to turn down; second, another tuberculosis hospital to relieve overcrowded conditions in the present one; third, five medical staff members, and particularly, a full time capable radiologist; fourth, additional medical technologists, medical social workers, and occupational therapists. The present patient load at the main hospital is 5,861, and that at the Arcadia branch hospital is 887. At the Arcadia branch hospital there is need for an additional physician.

The committee recommends that the Florida Medical Association render whatever assistance possible in meeting the needs of these various institutions.

Respectfully submitted,
Lloyd J. Netto, *Chairman*

Dr. Jones moved that the report of the Committee on Representatives to Industrial Council be adopted, as published in the Handbook.

Seconded. Motion carried.

Report of Committee on Representatives to Industrial Council

Julius C. Davis, *Chairman*

Members of the committee were unable, as requested by President Joseph S. Stewart, to send a representative to the Congress on Industrial Health in Chicago, Jan. 18-19, 1949. We had very little time, and it was not possible for any of the members to arrange the trip.

A communication received from Dr. Frank L. Fort read in part: "There have been no complaints about industrial medicine (or surgery) except a few of the general practitioners complain of the $2.00 fee per office call."

Dr. L. Washington Dowlen suggests that every person falling under the jurisdiction of the Workmen's Compensation Act be immunized against tetanus with the use of tetanus toxoid as he saw it used in the Navy. This we believe is a good suggestion.

I have not contacted the new State Chairman of the Commission, but expect to do so soon. My contacts heretofore, however, have been most satisfactory.

Respectfully submitted,
Julius C. Davis, *Chairman*

Dr. Jones announced that this completed the report of Reference Committee No. 2, Public Policy.

Report of Reference Committee No. 3

Dr. Shaler Richardson, chairman of Reference Committee No. 3, Finance and Administration, was recognized and asked to present the recommendations of that committee.

Dr. Richardson: "Your committee approves the Report of the Delegates to the A. M. A., as it is printed in the Handbook."

Dr. Richardson moved that this report be adopted.

Seconded. Motion carried.

Report of Delegates to AMA Interim Session

Homer L. Pearson, Jr., and Louis M. Orr, II

The second Interim Session of the American Medical Association was held in St. Louis on November 30 and December 1, 2 and 3, 1948 with a total registration of 4.526. By and large, this session was an improvement over the one held in Cleveland last January. The registration was greater, and the scientific program seemed to attract larger and more interested groups.

The House of Delegates spent a very busy two days. Probably the items of greatest interest were the one relating to the organization of a national insurance company combining Blue Cross and Blue Shield and the one relating to assessing each member to provide an Educational Fund so that the American public can know the truth concerning compulsory health insurance.

The House of Delegates voted against combining the Blue Cross and Blue Shield in a national insurance company, but voted to establish a national enrolment agency. As you have already learned, the House voted an assessment of $25 on all members for the educational program.

There have been so many resolutions brought before the House relating to the practice of medicine by hospitals that a committee was named in June 1947 to investigate the matter and make recommendation. Dr. Elmer Hess was chairman of this committee. Eighteen months later he made a most interesting progress report, which was published in full in volume 138, number 16, page 1163 of the Journal of the American Medical Association, Dec. 18, 1948, in which he presented a discourse on the Code of Ethics of the American Medical Association and suggested that the entire problem be decided on the basis of ethics. This excerpt from the report is a good example:

> The membership of the American Medical Association comprises medical men of as many different colors as are in the spectrum. At one end is the physician who is not connected in any way with any organized business. He practices private medicine alone. He pays his own rent, maintains his own fees and depends for his livelihood on his own individual professional and business methods. He is dependent on no one but the patient who consults him. At the other end of the spectrum is the physician employed by an industrial organization on a fulltime salary, who does all of the medical work of the plant and even runs a temporary hospital with x-ray and laboratory services to care for immediate emergencies around the plant and supervises the physical health for employment and continued health during such employment of the employees. Between these two extremes are all sorts of arrangements with all their gradations of employment, salary, bonus or what have you, from the doctor who employs a young doctor to help him to the clinical group employed as salaried men or on a salaried and commission basis. This includes the Army, Navy and Public Health Service. The American Medical Association has recognized all of these persons as eligible to Fellowship if they are members of their component county and constituent state medical organizations or are members of the government services, et cetera. Therefore, it is necessary that the Principles of Medical Ethics be broad enough to cover and protect all these persons so long as the work they do is to the public benefit.
>
> In order to answer the critics of the American Medical Association on some of these matters which are causing dissension and controversy, such as "the hospitals and medical schools practicing medicine," it must be remembered that when such institutions violate that which we think is the "Code," some physician is guilty of unethical conduct or he is not, and he is the one to carry before the Judicial Council with charges of unethical conduct against him. The decision can only be made on the evidence presented.

It will be interesting to note the reaction of the radiologists to this report. They desire very strong measures with some disciplinary action against the hospitals which violate the rules.

Many reports and resolutions, much too lengthy to comment upon here, were presented and were published in the December 18 and December 25, 1948 issues of the Journal of the American Medical Association.

The outstanding feature of the scientific program was the portion devoted to television. Symposiums, lectures and operations were presented in a most interesting and enlightening manner. This method of presentation will be utilized more and more to the great advantage of the listeners as well as the essayists and operators.

Dr. W. L. Pressly of Due West, S. C., was selected the outstanding general practitioner of the year and was presented the General Practitioner Award.

Your delegates were present at every session of the House.

Respectfully submitted,
Homer L. Pearson, Jr.
Louis M. Orr, II
Delegates

Dr. Richardson: "In the report of the Board of Governors, and supplement, there are three recommendations which the Board recommended for approval."

a. Dr. Richardson moved that Hollywood be accepted as the meeting place for 1950.

Seconded. Motion carried.

b. Dr. Richardson moved that the Florida Academy of Public Medicine be discontinued and that its properties and affairs be transferred back to the Florida Medical Association.

Seconded. Motion carried.

c. Dr. Richardson moved that the president serve as chairman of the Board of Governors and that the change in the By-Laws be adopted.

Seconded. Motion carried.

Dr. Richardson moved that the report of the Board of Governors as printed in the Handbook, and supplement, be adopted.

Seconded and carried.

Report of Board of Governors

Duncan T. McEwan, *Chairman*

Four meetings of the Board of Governors were held as follows: April 14, July 25, October 18 and November 21.

A working budget for the Association's office for the fiscal year 1948-1949 was adopted on recommendation of the secretary-treasurer, Dr. Robert B. McIver.

The resolution for the establishment of Specialty Sections as part of the Scientific Assemblies, adopted by the House of Delegates at the April 13, 1948 meeting and published in the June Journal on page 730, was reviewed by the Board to determine the best method to put the suggestions into practical operation. The Specialty Groups for many years have held meetings prior to the date of the Association's annual meeting and have made a real contribution to the success of the annual convention. Your Board found that the reaction was unfavorable to abruptly discontinue the Specialty Group meetings.

To solve the problem the Board appointed a special committee to make recommendations. This committee met all day one Sunday with Drs. Joseph S. Stewart, president, Robert B. McIver, secretary-treasurer, Chas. J. Collins, chairman of the Association's Scientific Work Committee and Stewart Thompson present. The report of the committee was fully discussed and its recommendations adopted, which follow:

1. That the Association's secretary present this problem to the Specialty Groups at the next annual meeting in order to get the viewpoints of the Groups as a whole for the benefit of the entire membership.

2. That the Scientific Assemblies of the State Association meeting continue as heretofore except that the Scientific Work Committee be given the authority to invite the various Specialty Groups to submit applications for papers for presentation at the Scientific Assemblies.

3. That the Scientific Work Committee be empowered to accept papers from any out-of-state speakers who are invited by any of the Specialty Groups or by the Scientific Work Committee to be presented at a Scientific Assembly.

4. That the State Association be responsible for the payment of only that part of the expenses of the additional guest speakers caused by the additional time necessary for their appearance before the Scientific Assembly.

5. That rooms be assigned to the various Specialty Group Societies on Sunday, as heretofore, but that the State Association is not to furnish projecting lanterns or any of the equipment necessary for the holding of such meetings.

Provision was made for five Scientific Assemblies which

will provide for more than twenty scientific papers to be presented. Essayists and guest speakers by this method may appear from the Specialty Group membership and still allow as many papers from the Association's membership at large as heretofore. It is hoped that this method, which is on a trial basis, will carry out the intent of the resolution and meet with general approval. Comments or constructive criticism will be appreciated.

The following members, on recommendations from their county medical societies, were elected to honorary membership: Drs. Elliott M. Hendricks, Lawrence L. Stepp (deceased), Jay A. Powell, B. L. Arms, Leonard A. Baker (deceased), Annette M. Feaster, Orion O. Feaster, John E. Hall, Sarah P. White, G. H. Withers, Nonie W. Gable.

The following telegram, dated April 9, 1948, was read by the secretary:

DR. ROBT B McIVER SECY FLORIDA MEDICAL ASSN
BOX 1018, JACKSONVILLE
PRELIMINARY PRINTS OF LEGISLATION YET TO BE INTRODUCED TO REACTIVE SELECTIVE SERVICE WILL AUTHORIZE SPECIAL CALLS FOR PHYSICIANS, DENTISTS AND VETERINARIANS UP TO FORTY-FIVE YEARS OF AGE. COUNCIL ON NATIONAL EMERGENCY MEDICAL SERVICE HAS EXPRESSED STRONG OPPOSITION TO THIS PROPOSAL ON THE GROUND THAT IT IS UNNECESSARY IN VIEW OF RECORD OF MEDICINE IN WORLD WAR II IN SUPPLYING NEEDED MEDICAL PERSONNEL, THAT IT IS DISCRIMINATORY IN THAT THE OTHER NEEDED SCIENTIFIC AND TECHNICAL PERSONNEL IS NOT SUBJECT TO SIMILAR CALL AND THAT IT REFLECTS ON PATRIOTISM OF PHYSICIANS BY INFERRING THEY WILL NOT RESPOND TO AN EMERGENCY. THE EXECUTIVE COMMITTEE OF BOARD OF TRUSTEES HAS REAFFIRMED THIS OPPOSITION. SUGGEST YOU TRANSMIT VIEWS OF YOUR ASSOCIATION WITHOUT DELAY TO SENATE COMMITTEE ON ARMED SERVICES, SENATOR CHAN GURNEY, CHAIRMAN TO HOUSE COMMITTEE ON ARMED SERVICES, CONGRESSMAN WALTER G. ANDREWS, CHAIRMAN, AND TO YOUR SENATORS AND CONGRESSMEN. URGENT.
J. W. HOLLOWAY JR AMERICAN MEDICAL ASSOCIATION

The Board approved the action of the National Emergency Medical Service and sent telegrams to our senators and congressmen and others named in the wire, stating our disapproval of calling medical men into selective service.

The report of Drs. Louis M. Orr, II, and Homer L. Pearson, the Association's delegates to the A.M.A. House of Delegates, which met in Chicago, June 21-24, 1948, was read and approved for publication in The Journal.

The Board reaffirmed its approval of the action taken by the House of Delegates of the A.M.A. in so far as blood bank organization is concerned, relating to the Red Cross.

Action was taken to discontinue the present policy of payment of smoker expenses at the annual meeting; that the secretary be empowered to set a fee for privileges to the smoker, in consultation with the local group on arrangements; that all revenue from the sale of smoker privileges above what is used for the smoker expenses shall be retained by the State Association; that any deficit be paid from State Association funds, if approved by the State Association's secretary.

A schedule of fees under Blue Shield, as set up by a committee with Dr. Orr as chairman, was adopted.

A schedule for the 1949 annual meeting in Belleair, April 11-13, 1949, as presented by Dr. Robert B. McIver, secretary, was adopted.

To clarify a misunderstanding, the Board went on record that, inasmuch as specialty groups are not provided for in the By-Laws, they be not considered a component part of the Florida Medical Association.

Action was taken that honorary members of the Association be given The Journal at a special rate of $3.00 per year.

Action was taken that the convention hotel manager be given the names of delegates, guest speakers and Association officers, requesting room reservations be made at the headquarters hotel, in order that those named may be assured of room reservations. It is understood that room reservations not confirmed at least two weeks in advance of the meeting may be used by other guests as the hotel manager sees fit.

A letter to Hon. Fuller Warren, Democratic Nominee for Governor of the State of Florida, respectfully urging that Dr. Wilson T. Sowder be reappointed State Health Officer when his four year term expires September 11, 1949, was approved and mailed.

Your Board received nominations from four county medical societies for the American Medical Association General Practitioner Award: Dr. Rufus Thames, Milton, by the Escambia County Medical Society; Dr. Robert C. Woodard, Miami, by the Dade County Medical Association; Dr. Isaac W. Chandler, Avon Park, by the DeSoto-Hardee-Highlands-Charlotte-Glades County Medical Society, and Dr. Frederick F. Kumm, St. Petersburg, by the Pinellas County Medical Society. A majority of the Board members cast their votes for Dr. Rufus Thames and his name was sent to Dr. George F. Lull, Secretary-Manager of the American Medical Association, by special delivery, registered mail, Monday, November 8, 1948. A copy of the letter was mailed to Drs. Homer L. Pearson and Louis M. Orr, II, the Association's delegates to the A.M.A.

Your Board approved the program of the Florida Association of Blood Banks and commended those responsible for the splendid work they are doing.

Your Board approved the efforts of the State Board of Health seeking to establish facilities for the treatment of drug addicts at the hospital at the State Prison Farm at Raiford. The Board of Governors requested to be informed as to the progress of the plan in order that it might at any time offer constructive criticism of the plan which is entirely in the embryonic stage.

Action was taken to go on record as disapproving the plan of the State Board of Health going into the physical examination field, and that we recommend to the State Forestry Service that they seek an appropriation from the state which would be sufficient to pay for the physical examinations to obviate the expense caused by the employment of unfit persons becoming a charge on state compensation.

A four page report from Dr. Leigh F. Robinson, president of Florida Medical Service Corporation, on the proposals of the Blue Cross-Blue Shield Commissions for a national health was extensively discussed and the following recommendations strongly approved:

a. That it approve in principle a National Health Service providing that any plan proposing to provide Medical Care benefits be approved by the A.M.A.

b. That it recommend to the House of Delegates that the Board of Governors of the Florida Medical Association favors a National Health Program and petitions the House of Delegates to take the necessary steps to develop such a program either by initiating same or through an acceptable relationship with the Blue Shield Commission.

c. That it also recommend to the Blue Shield Commission that its charter be amended to provide that the organization be placed in a similar relationship to the American Medical Association as the Blue Cross Commission enjoys with the American Hospital Association.

Approval was given to the request for a diabetic educational program, presented by Dr. Wilson T. Sowder, State Health Officer.

A communication from Dr. George F. Lull, Secretary-Manager of the A.M.A., attaching a resolution adopted by the House of Delegates of the A.M.A., was read. It urged state medical associations to budget sufficient funds to defray the cost of the activities of its auxiliary and to pay the annual dues of the national auxiliary, thus making the wife of every member automatically a member of the state and national auxiliaries and eliminating the collection of state and national auxiliary dues from individual auxiliary members.

Your Board went on record as disapproving the Florida Medical Association participating in the auxiliary plan set forth in this resolution.

Action was taken to invite the following to a meeting to be held prior to the convening of the 1949 session of the Legislature:

Florida Medical Association
- Board of Governors
- Committee on Legislation and Public Policy
- Committee on Public Relations
- Florida Academy of Public Medicine

State Board of Medical Examiners

Legislative Committees of following state associations:
- Dentists
- Pharmacists
- Veterinarians
- Hospital Association

State Board of Health—members and health officer
Blue Cross—Blue Shield

Supplement

After the Handbook for Members of the House of Delegates went to press a meeting of the Board of Governors was held in Jacksonville, February 27. This supplement, which is in addition to the printed report, is therefore offered to be included as a part of the original report.

Two choices are offered as meeting places for the Seventy-Sixth Annual Meeting of the Association in 1950: the Belleview-Biltmore Hotel at Belleair, and the Hollywood Beach Hotel at Hollywood. The facilities at the Hollywood Beach Hotel have been investigated and they are adequate.

It is requested that one of these hotels be selected by the House of Delegates, and that the meeting dates be set by the Board of Governors as provided by the Constitution and By-Laws.

On recommendation of the Board of Directors of the Florida Academy of Public Medicine, it is recommended to discontinue the Academy as the agency of public relations for the Florida Medical Association, and that the following resolution be adopted by the House of Delegates:

Resolution

Whereas, We consider the Florida Academy of Public Medicine has served its purpose for the Florida Medical Association; and

Whereas, There is no further need for the services of the Florida Academy of Public Medicine; and

Whereas, The Florida Medical Association will carry on its own program of Public Relations; therefore be it,

Resolved, That the Florida Academy of Public Medicine be requested to discontinue its activities and transfer its properties and affairs back to the Florida Medical Association.

It is recommended that hereafter the president of the Florida Medical Association be the chairman of the Board of Governors, and that By-Laws, Chapter VII—Regular Committees, Sec. 2, (paragraph 67), line 15, "The President shall select the chairman of this committee." be deleted and in lieu thereof, "The President shall be the chairman of this committee." be inserted.

A joint conference of interrelated organizations was held in Jacksonville, January 23, 1949. Representatives from each of the organizations, with particular emphasis on the chairmen of legislative committees, were in attendance. President Joseph S. Stewart was the moderator.

A resolution was adopted by the Board urging that Senate Bill 614, introduced in the 81st Congress, that would amend the Hospital Survey and Construction Act of the 79th Congress, be amended in several instances. A copy of the resolution was sent to each member of our Florida Congressional delegation, together with a letter of transmittal expressing appreciation for the enthusiastic support which we understand our delegation has given to Senate Bill 614 and the amendments herein recommended, and encouraging their continued support.

Respectfully submitted,
Duncan T. McEwan, *Chairman*

Dr. Richardson: "I move the approval of the report of the Committee on Scientific Work, as printed in the Handbook."

Seconded. Motion carried.

Report of Committee on Scientific Work

Chas. J. Collins, *Chairman*

The Scientific Program for the 1949 annual meeting has been considerably expanded in order to place more emphasis on this feature and provide a more balanced meeting. Five scientific assemblies have been allotted for the program. An effort has been made through the secretaries of the Specialty Societies to have one or more representative from each society on the program. Most of the secretaries have been very cooperative and the Committee on Scientific Work is indebted to them for their aid in obtaining essayists. The majority of the Specialty Societies will be represented on the program. In addition three distinguished guest speakers, appearing on the programs of three societies, also will appear before the scientific assemblies.

A meeting of the Committee on Scientific Work, with a full attendance, was held on December 12 when the final program was drafted. The chairman wishes to express his appreciation to all members who worked so diligently in this preparation.

There will be twenty-one papers presented, eighteen by members of the State Association and three by guest speakers. This represents an increase of nine papers over the 1948 annual meeting. It is believed that the 1949 Scientific Program will be so varied and general in interest that the members of the State Association will be induced to remain throughout the entire session.

Respectfully submitted,
Chas. J. Collins, *Chairman*

Dr. Richardson moved to approve the report of the Committee on Legislation and Public Policy, as printed in the Handbook, and approval of the supplemental report after striking out paragraph three (3) pertaining to licensing medical technologists.

Seconded. Motion carried.

Report of Committee on Legislation and Public Policy

W. Duncan Owens, *Chairman*

Your committee wishes to report that the activities have been increasing steadily. A great deal of effort has been put into the schedule to be prepared for the next session of the Florida legislature which will be in session before the end of our annual convention.

One new feature is to have a committee on legislation for each of the thirty-five county medical societies. Since secretaries of county medical societies are busy practitioners and swamped with many duties, it will certainly

be more effective for us to contact the chairman of the local committee on legislation for matters of this type. Heretofore only a few of the larger societies had their own committee on legislation.

After the election a card record was made on each senator and each representative, and pertinent information has been compiled on each individual. The name of the personal physician of each senator and representative has been obtained, and they have been requested to contact their representatives in the legislature in order to familiarize them with the efforts of the medical profession to care for the health of the citizens of our state. A number of county medical societies have invited their senators and representatives to attend a get-together meeting and discuss problems that may arise in the legislature. This also is a splendid opportunity to become better acquainted with the senators and representatives, which is a great asset in solving problems.

The House of Delegates, at the April 13, 1948 meeting, adopted a resolution recommending that the services of some person who is a lawyer or otherwise professionally qualified be engaged to act as consultant on legislative matters, etc. (page 730, June 1948 Journal). Mr. James E. Messer, Jr., an attorney, Tallahassee, who has been engaged to act as legislative consultant, is a man of good character, highly recommended, and agrees that no money should be paid to a senator or representative with a view of influencing his vote. The engaging of the services of Mr. Messer was approved by a joint committee, of which Dr. J. Maxey Dell, Jr., is chairman, representing the Florida Medical Association, Blue Shield, Blue Cross, and Florida Hospital Association.

Through doctors known to be influential with the president of the senate and the speaker of the house, efforts have been made to have appointed on the Public Health Committee, in both senate and house, persons who understand the value of public medicine.

A copy of Hygeia is being sent to each senator and representative, the governor and certain members of his cabinet and also to United States senators and congressmen. Letters have been received from many of the recipients of this favor, expressing their appreciation.

Many meetings and conferences have been held, personal contacts made, communications written and numerous other activities which would be too voluminous to include in this report.

Your committee is on the job and will continue throughout the session of the legislature. Mr. Ernest R. Gibson, as supervisor of the Association's public relations program, is devoting a large portion of his time to the activities of this committee. The help of this additional member of the staff of paid employees should be a tremendous asset in carrying out policies and handling voluminous details.

Supplement

Since rendering of the annual report of the Committee on Legislation and Public Policy your chairman is informed that several resolutions will be, or may be, presented to the House of Delegates for action. It is felt that comment on these resolutions is indicated:

1. A resolution decrying the practice of naturopathy in the State of Florida. It is our recommendation that this resolution be approved.

2. A resolution requesting opposition to any legislation which sets up or tends to point toward compulsory sickness insurance in the State of Florida. It is our recommendation that this resolution be approved.

4. A resolution requesting the approval of a bill anticipated being introduced into the 1949 session of the state legislature providing for the certification of psychologists. Your committee recommends no action regarding this proposed legislation.

5. A resolution requesting the Florida Medical Association to go on record as being in disapproval of a bill already introduced into the 1949 session of the state legislature which would transfer the sanitary inspection of eating establishments in hotels and restaurants from the State Board of Health, and county health units, to another agency of the State. Your committee heartily recommends the adoption of the resolution voicing disapproval of this proposed legislation.

6. A resolution requesting approval of a new schedule of fees relating to industrial surgery. Your committee urges the adoption of this resolution.

Respectfully submitted,
W. Duncan Owens, *Chairman*

Dr. Richardson moved that approval be given the report of the Committee on Public Relations, as printed in the Handbook.

Seconded. Motion carried.

Report of Committee on Public Relations

Frank G. Slaughter, *Chairman*

The Public Relations Program of the Florida Medical Association has been handled during the year largely through the Florida Academy of Public Medicine, the organization entrusted with this duty by the House of Delegates on recommendation of the Board of Governors. At the annual meeting of the Academy of Public Medicine in St. Augustine in April 1948 your chairman was elected a member of the Board of Directors of the Florida Academy of Public Medicine and has served on this board during the year, attending all meetings.

At a special meeting of the Board of Directors of the Academy, held in August 1948, your chairman was appointed as chairman of a special committee to meet with representatives of the Blue Cross, Blue Shield and Florida Hospital Association for the purpose of undertaking a joint program of action upon legislative matters, with particular reference to joint action in the matter of employing a representative for the period of the 1949 session of the Florida legislature and maintaining an information bureau in Tallahassee during that period. Your chairman has attended all meetings of this joint committee and has taken an active part in planning this legislative program.

Your chairman has also served in an advisory capacity to the Executive Secretary of the Florida Academy of Public Medicine in the entire public relations program and has been active in its planning and implementation. In this connection he has prepared a thirty minute address, THE ISSUE OF COMPULSORY HEALTH INSURANCE, now being made available to all members of the Association upon request, and has aided in the preparation of news releases on pertinent subjects from time to time.

On Nov. 18, 1948, at the request of the Jacksonville Junior Chamber of Commerce, your chairman upheld the negative in a debate with Senator Claude Pepper on the question: "Should the Congress Enact Compulsory Health Insurance Legislation?" This debate was held before a large audience and was broadcast over the radio. A mimeographed copy of the arguments used in refuting Senator Pepper's contentions has been sent to all members of the Florida Medical Association, an editorial upon this subject has appeared in The Journal of the Association, and it has been the subject of a news release. Your chairman has also spoken on this subject in several other cities during the year.

With the assessment of $25.00 upon all active members of the American Medical Association for educational purposes, your chairman has been in regular communication with those in that organization who have charge of the program and has offered his assistance in integrating the program of the Florida Medical Association into the national program. At the time of this report, the committee is awaiting further information. Your chairman has, however, personally suggested to Dr. Lull, Secretary-Manager of the American Medical Association, that some portion of the funds accumulated by the assessment should be allotted to the state associations who have active public relations programs, such as this Association has. To date, no action has been taken on this suggestion.

At the close of the year, the public relations program of the Florida Medical Association is being actively prosecuted and will be described in detail in the report of the Florida Academy of Public Medicine.

Respectfully submitted,
Frank G. Slaughter, *Chairman*

Dr. Richardson moved that the report of the Advisory to Woman's Auxiliary Committee be approved, as published in the Handbook.

Seconded. Motion carried.

Report of Committee on Advisory to Woman's Auxiliary

J. Lloyd Massey, *Chairman*

The Committee on Advisory to the Woman's Auxiliary was requested to advise the Auxiliary on participation in the project of medical and surgical relief to persons in devastated areas overseas. It was the opinion of the committee that the Auxiliary should not undertake this project.

Respectfully submitted,
J. Lloyd Massey, *Chairman*

Dr. Richardson moved that the report of the Council, as published in the Handbook, together with the supplemental report, be approved.

Seconded. Motion carried.

Report of Council

Herman Watson, *Chairman*

As chairman of the Council, it is my pleasure to report that no appeals have been received during the fiscal year. This would indicate that no physician has felt aggrieved by the action of the medical society of his county in refusing him membership, or in suspending or expelling him. The Council has stood ready during the year to act on any problem that should be referred to it.

Last fall the doctors from Madison County expressed their desire to make application for a Madison County medical society. At a joint meeting held with the members of the Madison-Suwanee County Medical Society it was approved by both groups, with the understanding that the three practitioners who are not members of the State Association would pay their 1949 dues in advance in order that this application might be acted on by the Council in time to be included in this report. However, there are only two members in Madison County, and the other three practitioners have as yet not sent in their 1949 dues. If the state dues are paid by the nonmembers, the application for charter will be taken up by the Council, and I will read a supplemental report at the meeting of the House of Delegates setting forth the recommendation of the Council. It is obvious that this recommendation cannot be included at this time as it is too late for the Handbook for Members of the House of Delegates.

Four medical district meetings were arranged by the Council and held during the month of October, 1948. The proceedings of these four medical district meetings were published in the December Journal on page 377.

The total registration at the four meetings was 333. Postmeeting echoes have been very favorable.

The officers of the State Association took a week off to attend the meetings at which eight scientific papers were presented. Each officer made a short address which was of unusual interest.

As retiring chairman of the Council, I wish to thank the officers of the Association for their splendid cooperation, and particularly to commend the essayists who presented papers. Also, I wish to express deep appreciation to the eight Councilors whose names appear below, who have been untiring in their efforts throughout the year: William P. Hixon, John M. Butcher, Irby H. Black, H. Quillian Jones, Charles C. Grace, Erasmus B. Hardee, Rabun H. Williams and Russell B. Carson.

Supplement

An application has been received requesting a charter for a Madison County Medical Society and an application for a charter for a Suwannee County Medical Society. At the present time this is a joint society known as the Madison-Suwannee County Medical Society.

There is now a new hospital in Suwannee County and the doctors in Madison County have made application for a hospital to be built in Madison County.

A joint meeting of the doctors from both counties was held some months ago and all of the details discussed. It is the consensus that it would be advisable to issue separate charters for the two county medical societies. Dr. Irby H. Black, Councilor of this district, met with the group and approves the recommendation.

A vote of the Council was taken and a majority of the Councilors voted in favor of the separate county medical societies.

It is, therefore, recommended that the House of Delegates approve the issuance of the two charters.

Respectfully submitted,
Herman Watson, *Chairman*

(At this point Dr. Richardson was interrupted for election of officers at 12:00 noon)

The Chair called for nomination of president-elect.

Dr. Lloyd J. Netto was recognized.

Dr. Netto: "Mr. President, Members of the House of Delegates and of the Florida Medical Association, I would like to place in nomination a man whom I believe has definitely earned his spurs as a hard worker in this organization. He is known to everyone, so there is no point in my trying to make a flowery speech. This man has served in many capacities, and has never refused to accept any responsibility. I wish to place in nomination the name of Dr. Herbert White of St. Augustine."

Nomination was seconded by Drs. Cleveland, Jelks and Collins.

Dr. Leland F. Carlton moved the nominations close.

Seconded. Motion carried.

Dr. Jones moved that the secretary cast the ballot for Dr. White and that he be declared president-elect.

Seconded and carried.

The Chair called for nominations for first vice president.

Dr. McIver: "I nominate Dr. David R. Murphey, Jr., of Tampa."

Motion was made and seconded that the nominations close and that the secretary cast the ballot for Dr. Murphey as first vice president.

Motion carried.

The Chair called for nominations for the office of second vice president.

Dr. McIver was recognized and nominated Dr. M. Eldridge Black for second vice president.

Motion was made and seconded that the nominations close and that the secretary cast the ballot for Dr. Black as second vice president.

Motion carried.

The Chair called for nominations for third vice president.

The name of Dr. John M. Butcher of Sarasota was placed in nomination for third vice president.

Motion was made and seconded that the nominations close and that the secretary cast the ballot for Dr. Butcher as third vice president.

Motion carried.

The Chair called for nominations for secretary-treasurer.

Dr. Richardson moved that Dr. Robert B. McIver be placed in nomination for secretary-treasurer.

Motion was made and seconded that the nominations close and that the president cast the ballot for Dr. McIver as re-elected secretary-treasurer.

Motion carried.

The Chair called for nominations for the office of editor of The Journal.

Dr. Herbert L. Bryans moved that Dr. Shaler Richardson be nominated for the office of editor of The Journal.

Motion was made and seconded that the nominations close and that the secretary cast the ballot for Dr. Richardson as re-elected editor of The Journal.

Motion carried.

The Chair recognized Dr. Richardson, chairman of Reference Committee No. 3, in order that he might complete the report of this reference committee, which was interrupted for the election of officers.

Dr. Richardson moved that approval be given the resolution opposing Compulsory Health Insurance.

Seconded. Motion carried.

A Resolution Opposing Compulsory Health Insurance

WHEREAS, under a system of free enterprise, the American medical profession has established the world's highest standards of scientific performance, treatment, and research, thereby helping the United States to become the healthiest major nation in the world; and

WHEREAS, history proves that nations entering into any form of governmentally controlled medicine have always found it necessary to increase taxes for this purpose beyond any and all original estimates, thus leading these nations in the direction of moral degradation and bankruptcy; and

WHEREAS, the entrance of government into the practice of medicine has further proved to lead to a progressive deterioration of medical standards and medical care to the detriment of the health of the people, NOW THEREFORE,

BE IT RESOLVED, (1) That the House of Delegates of the Florida Medical Association in an official assembly being held at the Belleview-Biltmore Hotel, Belleair, Florida, does hereby unanimously go on record as being unalterably opposed to any form of compulsory health insurance or any system of political medicine designed for bureaucratic control;

(2) That a copy of this resolution be forwarded to the President of the United States, to each Senator and Representative from the State of Florida, the Governor of the State of Florida, and each Member of the Legislature of the State of Florida, and that said representatives of the people be, and hereby are respectfully requested to use every effort at their command to prevent the enactment of any such legislation, be it Federal or State.

Dr. Richardson moved that approval be given the resolution concerning the increasing tendency on the part of state and federal governments to infringe on private enterprise.

Seconded. Motion carried.

Resolution

WHEREAS the members of the Florida Medical Association have noted an increasing tendency on the part of state and federal governments to infringe on private enterprise, and

WHEREAS there appears to be alarming effort to increase and expand social benefits already provided by law to an extent which endangers individual freedom and private enterprise, and

WHEREAS it has been brought to our attention that the Florida Industrial Commission has advocated modification of the existing statutes on workmen's compensation to add cash sickness benefits and other provisions, and

WHEREAS this body envisions this plan of remuneration for time off from work due to illness as an entering wedge for additional benefits such as medical and hospital care, thus being the beginning of a form of state compulsory sickness insurance, NOW THEREFORE

BE IT RESOLVED that the House of Delegates of the Florida Medical Association hereby go on record as voicing its unqualified opposition to any legislation which sets up, or tends to point the way to a form of compulsory sickness insurance, by whatever name it may be known, and

BE IT FURTHER RESOLVED that the secretary of the Florida Medical Association be directed to convey this expression of opinion to the Governor, the members of the Senate and the members of the House of Representatives of the State of Florida.

Dr. Richardson: "With reference to the resolution opposing compulsory health insurance as submitted by the Duval County Medical Society, your committee recommends its approval in principle, but we felt that the sense of the resolution was embodied in Resolutions 2 and 3, and that it was not necessary to formally approve the resolution."

Dr. Richardson moved that this resolution be approved in principle and that it be not published in The Journal.

Seconded. Motion carried.

Dr. Richardson announced that this completed the report of Reference Committee No. 3, Finance and Administration.

Dr. Stewart: I will ask Dr. Bryans and Dr. Rowlett to escort the new president, Dr. Walter C. Payne, to the platform.

Dr. Payne: "Mr. Past President, Members of the Florida Medical Association, Ladies and Gentlemen: I am well aware that at no time in the history of our country has the medical profession faced the serious problems which today confront us. For twenty-five years we have seen the trend toward socialized medicine gradually gain momentum and today the threat of socialized medicine is imminent. We are heartened, however, by the fact that at long last we are throwing off our lethargy and our complacency; and our American Medical Association is assuming the leadership for which we have longed. All of you know of the progress—the well-planned, aggressive positive program that the American Medical Association has inaugurated. One phase of the program is intended to educate and inform our people of the dangers that threaten us, and I ask you, who is better qualified by reason of experience, and by reason of education, to inform them than the members of our profession. We must cease to think of our doctors of medicine solely as dispensers of medical service. The time has come when we must take our rightful place as citizens in the broad sense—citizens of our country to create, to mold and to direct public opinion. In their fight against disease our doctors are daily saving human lives and we are proud of our progress and our record. I do not believe, however, that we can any longer escape our responsibility and our duty to come to the aid of our American way of life at a time when it is seriously threatened and at a time when the hopes of liberty-loving people all over the world may well depend on the outcome. This problem of socialized medicine is not one that simply involves the type and the quality of medical care that our people are to receive, nor its method of distribution, but. gentlemen, it is a problem that involves the entire political, social and economic structure of the largest, and one of the last, great free nations on earth.

For this high honor which you have given me today, I offer you the sincere thanks of a grateful heart, and I pledge that during my administration, and afterwards, I will strive to see that the Florida Medical Association assumes its full responsibility, not only in combating socialized medicine, but in preserving the principles of our democracy."

Dr. Payne requested Dr. Stewart to come forward.

Dr. Payne: "I approach my first official act with mixed emotion. It is a pleasure to do honor to our retiring president. It is, however, with a feeling of nostalgia that I see him relinquishing the duties and the responsibilities of this office. The picture however is brightening, for the fact that while he is bowing out as our president, he will continue to play an important role in the affairs of the Florida Medical Association. He will continue to be Florida's representative on the Committee of Fifty-Three of the American Medical Association. He will continue to be the chairman of the Coordinating Committee, acting as liaison between our Association and the American Medical Association. He will continue to serve on the Board of Governors. I think that his type and caliber of statesman can be somewhat illustrated by a talk he made recently in Jacksonville. He had called a meeting of representatives of the county medical societies and the ladies' auxiliaries for the purpose of giving them a blueprint of the American Medical Association's current program, and I would like to quote from his opening remarks at that meeting: 'We are assembled here today for three reasons, (1) because we love this great country of ours, (2) because we love our American way of life with its system of free enterprise, and (3) because we are interested in improving the medical care of our people and are willing to do what we can so that the health of our citizens is better and better.'

I think that it is providential that at this particular time a man of Joe's vision, of his energy, and of his courage should have been president of our Association. I have been closely associated with Joe, particularly during the past two years, and his wise counsel has been an inspiration; and the knowledge that I can call on him during my administration for further advice is a source of comfort.

It is the custom of this Association to present its retiring president with a certificate of honor and so it is, Joe, that speaking for the Florida Medical Association, I have the honor, the privilege, and the very great pleasure of presenting to you this past president's certificate of honor.

I also have the pleasure of presenting to you a past president's button. May the affairs of this Association always be conducted in a manner so that you may wear this pin with pride, and as you go about your daily routine of treating the sick and the suffering, may this pin be a constant reminder of the love, the respect and the high esteem in which you are held."

Dr. Payne: "We have in our audience today one of the most deeply honored of our profession. As you know, each year the A. M. A. gives a citation for the outstanding general practitioner. This recipient is chosen from a list of one candidate from each state, and we have with us today Florida's candidate for that honor. He happens to be a member of my own society and I have been closely associated with him for the last thirty-five years, and I have come to love, admire and respect him. He has the admiration of everyone in his community, and no one knows better than I how much he deserves this statewide recognition. Since he is one of the most loyal friends I have ever had it gives me a particular pleasure to present to you, Dr. Rufus Thames of Milton."

The Chair called for unfinished business.

Dr. Edwin H. Andrews was recognized and presented a resolution of appreciation in behalf of Reference Committee No. 1, Health and Education.

Dr. Andrews moved the adoption of this resolution of appreciation.

Seconded. Motion carried.

Resolution of Appreciation

Be It Resolved that the Florida Medical Association go on record as expressing its deepest appreciation to the Pinellas County Medical Society and the Hillsborough County Medical Society and all of their committees on arrangements for their diligent efforts and accommodations in making our meeting of 1949 most successful and enjoyable.

Be It Resolved that our appreciation and gratitude to the personnel of the Belleview-Biltmore Hotel and other hotels of this vicinity which have accommodated members of the Florida Medical Association be extended for their most cooperative work in connection with this meeting.

Be It Resolved that thanks and gratitude be extended to the civic authorities in this community for their cooperation which has made this a most successful and pleasurable meeting.

Respectfully submitted,
Reference Committee No. 1

Announcements.

The Chair requested all members of the Board of Governors to remain for a meeting of the Board, immediately following adjournment by the House.

The Chair announced that a bill condemning socialized medicine which had been introduced at the State Legislature by Senator Claude Alford had been passed, with a vote of 36 to 4, and suggested a vote of thanks be rendered Senator Alford.

Dr. Courtland D. Whitaker was extended the courtesy of the floor.

Dr. Whitaker: "I move that we send a vote of thanks to Senator Claude Alford."

Seconded. Motion carried.

There being no further business, on motion duly seconded and carried, the House of Delegates adjourned, sine die, at 12:35 p.m.

SCIENTIFIC ASSEMBLIES

First Scientific Assembly

The first Scientific Assembly convened at 9:15 a.m., Monday, April 11, in The Starlight Room with Dr. Chas. J. Collins of Orlando presiding. The following papers were read and discussed:

"Early Ambulation of the Fused Low Back," Royston Miller, Newton C. McCollough and Eugene L. Jewett, Orlando.

"Pyuria; a Study of One Hundred Cases," Frank J. Pyle, Orlando.

"Hematuria; Its Clinical Significance," Clarence G. Bandler, New York City.

"Cancer of the Breast; a Comparison of Findings in a Charity Clinic and in a Private Clinic," Edward Jelks and A. T. Kennedy, Jacksonville.

"What May Be Expected of Radiation Treatment of Nonmalignant Diseases," Thomas H. Lipscomb, Jacksonville.

Second Scientific Assembly

The second Scientific Assembly convened at 3:30 p.m., Monday, April 11, in The Starlight Room with Dr. Chas. J. Collins of Orlando presiding. The following papers were read and discussed:

"General Allergies in Children," Charlotte C. Maguire, Orlando.

"Early Closure of Burn Areas," Michael L. Mason, Chicago.

"Cancer of the Skin in Florida," Wesley W. Wilson, Tampa.

"The Diagnosis and Treatment of Infertility," Oren A. Ellingson, Tampa.

Third Scientific Assembly

The third Scientific Assembly convened at 9:00 a.m., Tuesday, April 12, in The Starlight Room with Dr. Frederick K. Herpel of West Palm Beach presiding. The following papers were read and discussed:

"Diagnosis of the Commoner Hemorrhagic Diseases," James N. Patterson, Tampa.

"Heart Disease; a Clinical Evaluation," Spencer A. Folsom and William H. Kelley, Orlando.

"The Management of Eclamptogenic Toxemia," Frederick H. Falls, Chicago.

"Modern Concepts of the Prevention and Treatment of Puerperal Infection," Homer L. Pearson, Jr., Miami.

"The Circus," Joseph Halton, Sarasota.

Fourth Scientific Assembly

The fourth Scientific Assembly convened at 3:30 p.m., Tuesday, April 12, in The Starlight Room with Dr. Jere W. Annis of Lakeland presiding. The following papers were read and discussed:

"Pediatrics: Current Trends in Practice and Training," Warren W. Quillian, Coral Gables.

"The Master Two Step Exercise Test in the Diagnosis of Coronary Insufficiency," Karl B. Hanson, Jacksonville.

"Urologic Consideration of Urinary Incontinence in the Female; Analysis of One Hundred and Twelve Cases," Arthur J. Butt, Pensacola.

"Modified Autohemic Therapy Treatment," John A. Mease, Jr., Dunedin.

Fifth Scientific Assembly

The fifth Scientific Assembly convened at 9:00 a.m., Wednesday, April 13, in The Starlight Room with Dr. James L. Borland of Jacksonville presiding. The following papers were read and discussed:

"Streptomycin Therapy in Granuloma Inguinale," Roger F. Sondag, Jacksonville.

"Comments on Diverticula of the Gastrointestinal Tract," Gerard Raap, Miami.

Dr. Carlos P. Lamar of Miami was scheduled to read his paper on "The Management of Complications of Diabetes Mellitus;" however, Dr. Lamar was reported as being ill and his paper was not read.

REGISTRATION

The registration for the Seventy-Fifth Annual Meeting at Belleair surpassed that of any previous convention of the Association. The total number registered was 1,147 persons. The registrants included 618 members of the Association, 84 visiting physicians, 10 other guests, 332 members and guests of the Woman's Auxiliary and 103 representatives of exhibiting firms. An interesting note is the excellent representation of other states. Twenty-one states and two foreign countries were represented.

Registration List

Officers

Joseph S. Stewart, President ..... *Miami*
Walter C. Payne, President-elect ..... *Pensacola*
Herbert E. White, 1st Vice President ..... *St. Augustine*
Reddin Britt, 3rd Vice President ..... *St. Augustine*
Robert B. McIver, Secretary-Treasurer ..... *Jacksonville*
Shaler Richardson, Editor ..... *Jacksonville*
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Walter Clifton Payne, M.D., President

Walter Clifton Payne was born Jan. 30, 1889 in Luverne, Ala. He received his premedical education at the University of Alabama in Tuscaloosa and obtained his medical degree from Tulane University of Louisiana School of Medicine in 1912. From 1912 to 1914 he served as an intern in the Charity Hospital in New Orleans. Shortly after the outbreak of World War I, he joined the United States Navy and served from 1917 to 1919.

He began private practice in Pensacola in 1914 and has resided in that city since that time. He married Miss Vivian Ballard of Andalusia, Ala., and they have two children, Vivian and Dr. Walter Clifton Payne, Jr.

Dr. Payne is a past president of the Escambia County Medical Society and of the Medical Staff of the Sacred Heart Hospital in Pensacola, where he is a charter member of the Surgical Staff.

He has served as a member of the Board of Governors of the Florida Medical Association continuously since June 1938 and acted as chairman in 1947. He also served the Association as a Councilor for a number of years and was chairman of this group for one year.

He is a past president of the Pensacola Rotary Club, the Pensacola Community Chest and the Escambia Tuberculosis and Health Association. For a number of years he was chairman of the Executive Committee of the Escambia Chapter of the American Cancer Society and has acted as chairman of the Medical Advisory Committee of the Escambia Chapter of the National Foundation for Infantile Paralysis for several years. He has acted as chairman of the Hospital Advisory Council to the State Improvement Commission in carrying out the provisions of the Federal Hospital Survey and Construction Act. He is also a member of the Florida Hospital Licensing Board.

Dr. Payne is a fellow of the American College of Surgeons, the Southeastern Surgical Congress and the American Medical Association.

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Second—TAYLOR W. GRIFFIN, M.D...2-51.....*Quincy*
Third—CHARLES C. GRACE, M.D...3-50.....*St. Augustine*
Fourth—CLELAND D. COCHRANE, M.D...4-51.*Daytona Bch.*
Fifth—M. CREGO SMITH, M.D...5-51.....*Clearwater*
Sixth—H. QUILLIAN JONES, M.D...6-50.....*Ft. Myers*
Seventh—ERASMUS B. HARDEE, M.D...7-50....*Vero Beach*
Eighth—S. MARION SALLEY, M.D...8-51.....*Miami*

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(Terms expire Dec. 31, 1950)

The Journal of the Florida Medical Association

OWNED AND PUBLISHED BY FLORIDA MEDICAL ASSOCIATION
P. O. BOX 1018 JACKSONVILLE, FLORIDA

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Annual Convention Held in Belleair

The Seventy-Fifth Annual Meeting of the Florida Medical Association, held in Belleair on April 11, 12 and 13, was the Association's event of the year. The total registration was 1,147, of which 618 were members of the Association, 84 were visiting physicians, 10 were other guests, 332 were members and guests of the Woman's Auxiliary, and 103 were representatives of exhibiting firms. Registration at this annual convention is the highest on record for the Association. In 1947 in Miami the total registration was 1,145.

At the Association's dinner on Tuesday evening, 465 plates were served in the hotel dining room. Of all previous meetings this was the record for any one meal. At the Belleview-Biltmore Hotel this year, however, a drastic change took place; on Sunday night, 703 plates were served, and on Monday night, 595. This shifting of attendance will be a problem to consider when arranging for hotel facilities in the future.

The Hillsborough County Medical Association and the Pinellas County Medical Society, with wives of local doctors, were untiring in their efforts to do everything possible for the comfort and pleasure of the members and guests.

Three general sessions, two meetings of the House of Delegates and five scientific assemblies were held in accordance with the printed program. Special group societies, numbering 16, met during Sunday with splendid programs of particular interest and were well attended. This was the largest number of special group society meetings held preceding any of the Association's annual meetings.

At the breakfast for the Board of Past Presidents on Wednesday morning, Dr. John A. Simmons of Arcadia was elected chairman and Dr. Joseph S. Stewart of Miami, secretary.

Dr. Dodge D. Mentzer of Lakeland won the Orlando Loving Cup at the medical golf tournament held on the Belleview-Biltmore course. To retain possession of the Orlando Cup it must be won three times by an individual.

The annual meeting in 1950 is scheduled for Hollywood with the Hollywood Beach Hotel as headquarters. The dates for this meeting were set by the Board of Governors for April 22-26, 1950.

The complete text of recommendations by the reference committees and actions taken by the House of Delegates may be found in the preceding pages of this Journal.

How Florida Can Contribute to Improvement of the National Health

Next to life itself, health is man's most prized possession. Accordingly, the collective health of our nation is one of the most vital factors in our over-all economy. The disagreement before the public today is over the best method by which the highest standards of national health can be obtained.

The President's request that the Congress base a national program upon compulsory health insurance may seem to many at first to be a courageous approach to the problem. More careful analysis, however, will show, first, that this method is a

radical departure from American tradition in that it will attempt not to lay down minimum standards and safeguards for the people, but rather to ensure all medical services for all the people; second, that the scheme will prove extremely costly; and third, that the quality of health care for the people as a whole will deteriorate.

Mr. Truman and his healthmate, Mr. Oscar Ewing, in departing from the time-honored methods of American tradition, have neglected to take note of the excellent strides which voluntary health insurance plans have made and have closed their eyes to endeavor in that direction.

United States citizens have endowed scores of hospitals, have contributed millions of dollars to drives against cancer, polio and tuberculosis, and have created the best medical schools in the world. They are members of a nation founded by rugged individualists, proud of their ingenuity and ability to solve their problems by voluntary methods. Why should they then relinquish their freedom and turn like sheep to methods of compulsion which have originated elsewhere and have until the present time almost invariably resulted in loss of both incentive and moral power?

United States Senator H. Alexander Smith of New Jersey recently was quoted as saying: "When I hear Mr. Ewing. . . . I think of a man who lives in a fine big house with a leaky roof. The man says, 'This is horrible. . . . We must tear down the house and go build a wonderful new jail and live in the jail instead.' . . . I have no enthusiasm at all for Mr. Ewing's jail."

Even by Mr. Ewing's own report, health in the United States is improving. The average life expectancy of its citizens has increased twenty years during the last half century. American medicine has solved the riddle of yellow fever and malaria, has put an end to epidemics of typhoid fever, scarlet fever and diphtheria, has reduced the incidence of tuberculosis to a small fraction of its former rate and has converted pneumonia and many other hitherto dangerous infectious diseases into relatively innocuous maladies. The big killers today are diseases of the heart and blood vessels, high blood pressure and cancer—diseases which may become preventable in the future not through compulsory health programs, but through organized instruction, study and research.

Everyone agrees that this country needs more good doctors of medicine and needs them badly. The only practical way in which they can be produced appears to be by establishing more medical schools and by insisting that the present high standards of medical education be maintained.

All recognized medical schools in the United States today are good. The second and third rate establishments were eliminated years ago. Many of the schools are, however, in a dangerous position because of inadequate budgets, and there is temptation, because of the crying need for new schools, to cut corners on expense necessary to the creation of first rate schools.

Florida is one of the few states in the union which does not have a medical school. High standards of medical practice have been maintained up to the present time, but now that medical schools throughout the nation have become overcrowded and have found it necessary largely to restrict their facilities for the use of citizens of their own states, Florida occupies a peculiar and embarrassing position. We have no facilities for medical education to offer the boys and girls of our own state; and likewise we have little technical training to offer students from other states which might induce those states to accept more of our students for medical training.

The importance of securing an outstanding medical school for our great state cannot be overemphasized. Action in that direction by a few in the past is greatly to be commended. Rivalry between the Florida cities presenting reasons why the school should be established in their environs has been keen and understandable.

Recently a statewide survey was made by Dr. Vernon W. Lippard, former dean of Louisiana State University School of Medicine, and on February 24, the Florida Survey Committee recommended the campus of the University of Florida at Gainesville as the site of a proposed $19,000,000 medical school. There are some, of course, who still believe that a larger city would be much more advantageous because it could offer better hospital teaching facilities necessary to proper instruction of medical students. Nevertheless, the survey committee after giving that point due consideration thought that other points outweighed it and unequivocally recommended the University of Florida campus as the site.

Most people recognize now that this project must transcend local interests and loyalties and that concerted action is imperative. By working together, the people of Florida can fulfill a long-cherished dream, can greatly improve the health of the state and thereby can materially contribute to improvement of the national health.

Special Course on Cardiovascular Diseases

Beginning on Tuesday, June 14, and continuing through Friday, June 17, a Special Course on Cardiovascular Diseases will be presented by the Department of Medicine of the Graduate School of the University of Florida at the George Washington Hotel in Jacksonville. The registration fee is $25, and the time set for registration is 8 a.m. on Tuesday, June 14.

Dr. Bruce Logue, cardiologist, and Dr. Robert P. Grant, Department of Cardiology, School of Medicine, Emory University, Emory, Ga., are the distinguished medical teachers who comprise the faculty. The program follows:

Tuesday, June 14, 1949

9:00 a.m.	"The Diagnosis and Treatment of Congestive Heart Failure," Dr. Logue
10:00 a.m.	"The Interpretation of Certain Clinical Signs of Heart Failure," Dr. Grant
11:00 a.m.	Recess
11:30 a.m.	"Coronary Disease," Dr. Logue
12:30 p.m.	Luncheon
2:00 p.m.	"The Meaning of the Electrocardiogram," Part I, Dr. Grant
3:00 p.m.	"The Meaning of the Electrocardiogram," Part II, Dr. Grant
4:00 p.m.	Recess
4:30 p.m.	"Acute Pericarditis and Chronic Constrictive Pericarditis," Dr. Logue

Wednesday, June 15, 1949

9:00 a.m.	"The Problem of Hypertension," Dr. Grant
10:00 a.m.	"The Management of Myocardial Infarction," Dr. Logue
11:00 a.m.	Recess
11:30 a.m.	"Cardiac Therapy," Dr. Grant
12:30 p.m.	Luncheon
2:00 p.m.	"The Differential Diagnosis of Anterior Chest Pain," Dr. Logue
3:00 p.m.	"Precordial and Unipolar Leads," Dr. Grant
4:00 p.m.	Recess
4:30 p.m.	Quiz Period

Thursday, June 16, 1949

9:00 a.m.	"Rheumatic Fever," Dr. Logue
10:00 a.m.	"The Diagnosis and Management of the Tachycardias and Arrhythmias," Dr. Grant
11:00 a.m.	Recess
11:30 a.m.	"The Clinical Interpretation of Murmurs and Their Differential Diagnosis," Dr. Logue
12:30 p.m.	Luncheon
2:00 p.m.	"The Electrocardiogram in Myocardial Infarction," Part I, Dr. Logue
3:00 p.m.	"The Electrocardiogram in Myocardial Infarction," Part II, Dr. Logue
4:00 p.m.	Recess
4:30 p.m.	"Less Common Forms of Heart Disease," Dr. Grant

Friday, June 17, 1949

9:00 a.m.	"Congenital Heart Disease," Part I, Dr. Logue
10:00 a.m.	"Congenital Heart Disease," Part II, Dr. Logue
11:00 a.m.	Recess
11:30 a.m.	"Cor Pulmonale," Dr. Grant
12:30 p.m.	Luncheon
2:00 p.m.	"The Indications and Limitations of the Electrocardiogram," Dr. Grant
3:00 p.m.	"Functional Aspects of Cardiovascular Disease," Dr. Logue
4:00 p.m.	Recess
4:30 p.m.	Quiz Period

Program of the Graduate Short Course June 20-25, 1949

The Seventeenth Annual Graduate Short Course, presented by the Department of Medicine of the Graduate School of the University of Florida in cooperation with the Florida Medical Association and the Florida State Board of Health, begins on June 20 and continues through June 25 at the George Washington Hotel in Jacksonville. The lectures are planned to interest all physicians of Florida and neighboring states, medical officers, hospital residents, interns and postgraduate students. Tuition is $10, and registration is scheduled for 8 a. m. on Monday, June 20.

Dr. Thomas M. Durant, Professor of Clinical Medicine, Temple University School of Medicine, Philadelphia, will lecture on the bedside diagnosis and the management of cardiac arrhythmias, jaundice, migraine, the problems of pulmonary disease, hyperthyroidism, and the diagnosis of pain in the thoracic region.

Dr. Keith S. Grimson, Associate Professor of Surgery, Duke University School of Medicine, Durham, N. C., in his lectures will discuss surgical diseases of the esophagus, the treatment of pathologic conditions of the pancreas, surgery of the rectum and colon, acute conditions of the abdomen, surgery of the hand, and the present status of recent developments in surgery.

Dr. James G. Hughes, Associate Professor of Pediatrics, University of Tennessee School of Medicine, Memphis, Tenn., has for his subjects the care of the premature infant, the management of acute purulent meningitis, obstructions of the alimentary tract in infancy and childhood, common feeding problems in infancy and childhood, the treatment of severe diarrhea in infancy, and psychosomatic pediatrics.

Dr. Frank R. Lock, Professor of Obstetrics and Gynecology, The Bowman Gray School of Medicine, Wake Forest College, Winston-Salem, N. C., will present lectures on the responsibility of the physician in the management of premature labor, methods of clinical estimation of the obstetric pelvis, postnatal care, heart disease complicating pregnancy, obstetric emergencies in the home, and what can be learned from maternal deaths.

Dr. John B. Cross, Acting Chairman, Department of Obstetrics and Gynecology, School of Medicine, Emory University, Emory, Ga., will lecture on inflammatory disease of the internal genitalia, ectopic pregnancy, ovarian tumors,

Schedule of the Short Course

Hour	Monday June 20	Tuesday June 21	Wednesday June 22	Thursday June 23	Friday June 24	Saturday June 25
8:00	**Registration**					
9:00	**Psychiatry** The Diagnosis and Treatment of Convulsive Disorders—Part I Dr. Crank	**Pediatrics** Obstructions of the Alimentary Tract in Infancy and Childhood Dr. Hughes	**Pediatrics** The Treatment of Severe Diarrhea in Infancy Dr. Hughes	**Obstetrics** Postnatal Care Dr. Lock	**Gynecology** Ovarian Tumors Dr. Cross	**Gynecology** Backache in Gynecology Dr. Cross
10:00	**Pediatrics** The Care of the Premature Infant Dr. Hughes	**Psychiatry** The Management of Anxiety States Dr. Crank	**Obstetrics** Responsibility of the Physician in the Management of Premature Labor Dr. Lock	**Gynecology** Inflammatory Diseases of Internal Genitalia Dr. Cross	**Obstetrics** Obstetric Emergencies in the Home Dr. Lock	**Surgery** Surgery of the Hand Dr. Grimson
11:00	**Recess**	**Recess**	**Recess**	**Recess**	**Recess**	**Recess**
11:30	**Medicine** Bedside Diagnosis of Cardiac Arrhythmias and Their Management Dr. Durant	**Medicine** Migraine Dr. Durant	**Medicine** Hyperthyroidism Dr. Durant	**Surgery** Surgical Diseases of the Esophagus Dr. Grimson	**Surgery** Surgery of the Rectum and Colon Dr. Grimson	**Gynecology** Leukorrhea Dr. Cross
12:30	**Lunch**	**Lunch**	**Lunch**	**Lunch**	**Lunch**	**Surgery** Present Status of Recent Developments in Surgery Dr. Grimson
2:00	**Pediatrics** The Management of Acute Purulent Meningitis Dr. Hughes	**Pediatrics** Common Feeding Problems in Infancy and Childhood Dr. Hughes	**Pediatrics** Psychosomatic Pediatrics Dr. Hughes	**Obstetrics** Heart Disease Complicating Pregnancy Dr. Lock	**Obstetrics** Maternal Deaths: What Can We Learn? Dr. Lock	
3:00	**Recess**	**Recess**	**Recess**	**Recess**	**Recess**	
3:15	**Psychiatry** The Diagnosis and Treatment of Convulsive Disorders—Part II Dr. Crank	**Psychiatry** The Management of Psychiatric Problems During and Past Middle Life Dr. Crank	**Medicine** The Diagnosis of Pain in the Thoracic Region Dr. Durant	**Gynecology** Ectopic Pregnancy Dr. Cross	**Surgery** The Acute Abdomen Dr. Grimson	
4:15	**Recess**	**Recess**	**Recess**	**Recess**	**Recess**	
4:30	**Medicine** Jaundice Dr. Durant	**Medicine** Pulmonary Disease Problems Dr. Durant	**Obstetrics** Methods of Clinical Estimation of the Obstetric Pelvis Dr. Lock	**Surgery** Treatment of Pathological Conditions of the Pancreas Dr. Grimson	**Gynecology** Benign Lesions of the Cervix Dr. Cross	
	Dinner	**Dinner**	**Dinner**	**Dinner**	**Dinner**	
8:00	**Psychiatry** Alcoholism Dr. Crank	**Medical Round Table Discussion**		**Surgical Round Table Discussion**		

benign lesions of the cervix, backache in gynecology, and leukorrhea.

Dr. H. Harlan Crank, Associate Professor of Psychiatry, Menninger Foundation School of Psychiatry, Topeka, Kan., will present lectures on the diagnosis and treatment of convulsive disorders, the management of anxiety states, the management of psychiatric problems during and past middle life, and alcoholism.

The program is published in full in this Journal.

Inquiries may be addressed to the Short Course Committee, 2033 Riverside Ave., Jacksonville.

BIRTHS, MARRIAGES AND DEATHS

Births

Dr. and Mrs. Robert Y. H. Thomas, Jr., Jacksonville, announce the birth of a son, Peter Ruffin, on April 9, 1949.

A daughter was born to Dr. and Mrs. Joseph R. Carver, Branford, on March 24, 1949.

Dr. and Mrs. Albert E. McQuagge, Marianna, announce the birth of a daughter in March, 1949.

Dr. and Mrs. Grayson C. Snyder, Blountstown, announce the birth of a son, Robert Scott, on March 13, 1949.

Marriages

Dr. Shaler Richardson and Mrs. Nada Coffee Bailey of Jacksonville were married on May 7, 1949 in Jacksonville.

Dr. Matthew E. Morrow of Jacksonville and Miss Sara Marion Watson of Jacksonville were married on April 8, 1949.

Deaths—Members

Joseph R. Carver, Branford ..... April 19, 1949

Deaths—Other Doctors

Harry W. Porter, East Point, Ga. ..... April 2, 1949
William J. Gatti, Philadelphia, Pa. ..... Recently
Oscar B. Tiller, Chipley ..... April 10, 1949
John T. Hosey, Palatka ..... April 23, 1949

"In Tribute to the American Doctor" is beautifully portrayed in the Philip Morris spread on pages 752 and 753 of this issue. They invite you to send for a copy suitable for framing. Display it in your reception room—your patients will enjoy reading it.

WANTED: Doctor, urgently needed, to take over established general practice. Contact Hal Y. Maines, Lake Butler, Fla.

FOR SALE: General practice, including equipment. Central downtown location in beautiful Sunshine City of St. Petersburg, Fla.; population, 100,000. Price, $5,000; easy terms. Leaving June 15 to accept residency. Will introduce. Write P. O. Box 658, Station A, St. Petersburg, Fla.

STATE NEWS ITEMS

The Interim Session of the American Medical Association, previously scheduled for Tampa, will be held in Washington, D. C., from Dec. 6 through Dec. 9, 1949. The Board of Trustees decided that Tampa would be desirable from every standpoint except that of attendance. Washington is so situated that a larger attendance is probable.

Dr. Arthur J. Butt, Jr., of Pensacola recently addressed the premedical student body at the Florida State University in Tallahassee on the "History of Urologic Surgery and Development of Urology As a Specialty."

Dr. Harold E. Winchester of Dunedin is the newly-elected president of the local Rotary Club. Dr. Everett M. Harrison was elected a director.

Dr. Ivan W. Gessler, program chairman of the Winter Haven Rotary Club, presented Dr. Marion W. Hester of Lakeland as the guest speaker at a recent meeting of the club. Dr. Hester spoke on the work now being done in eye surgery.

After a decade of service, the National Physicians Committee for the Extension of Medical Service ceased all activities on April 1, 1949 and set about liquidating its affairs in an orderly manner.

Dr. Joseph W. Douglas of Pensacola spoke recently before members of the Bay County Medical Society on "The Use of Estrogenic Substances in the Female."

Dr. Lowell S. Selling of Orlando spoke at the luncheon meeting of the Bartow Pilot Club in April. He explained the work of the Polk County Guidance Center and conducted an informal question and answer period.

Dr. John B. Turner of Bagdad was the guest speaker at the Milton Lion's Club in March. Following Dr. Turner's explanation of the need of a county hospital, members of the club passed a resolution favoring the construction of a Santa Rosa county hospital.

Dr. John P. Moore has returned to Ocala after three years residency in radiology in the clinic of Drs. Groover-Christie and Merritt at Washington, D. C. He will be associated with his father, Dr. John N. Moore, in the practice of radiology.

Dr. Wendell J. Newcomb has opened offices at 1206 North Palafox Street, Pensacola, for the practice of orthopedic surgery.

Dr. Thomas H. Bates of Lake City attended the annual meeting of the Atlantic Coast Line Surgeons which was held in Savannah, Ga., in April.

Dr. Leffie M. Carlton, Jr., of Tampa attended a meeting of the American Association for Thoracic Surgery which was held in New Orleans in March.

Dr. Walter Wilkins of Jacksonville discussed "Nutrition" at a meeting of the Twentieth Century Club in Gainesville in April.

Dr. Herman Selinsky and Dr. Ralph W. Jack, both of Miami, were speakers at the University of Miami's Marriage and Family institute in March. Dr. Selinsky spoke on "Adjustment of Husband and Wife," and Dr. Jack discussed the "Biological Basis of Parenthood."

NEW MEMBERS

The following doctors have joined the State Association through their respective county medical societies.

Batell, Leo, Tampa
Brill, Thomas M., Gainesville
Hardie, Arthur L., Jr., Jacksonville
Hawley, Hugh H., Jr., Miami Beach
Hughes, Paul W., Gainesville
Kindler, Daniel, Miami
Pichler, Floyd L., Jacksonville
Roberts, William V., Sanford
Rolfes, Harry F., Lake Wales
Sias, Charles R., Orlando
Steele, William T., Winter Haven

COMPONENT SOCIETY NOTES

Bay

At the regular April meeting of the Bay County Medical Society, Dr. William C. Roberts explained to the members the minimum standards, staff rules and regulations necessary for the new Memorial Hospital. The report was referred to committee for action at the May meeting.

Dr. James E. Kerr was in charge of the scientific program and introduced Dr. Samuel B. D. Rhea of Pensacola who spoke on gastrointestinal x-ray problems. His lecture was illustrated with x-ray pictures.

Brevard

At the March meeting of the Brevard County Medical Society, which was held at the Brevard Hotel in Cocoa, the program was devoted to a discussion of plans to fight the threat of compulsory health insurance. A resolution opposing government control of medicine was adopted.

Guests included dentists and pharmacists of the county.

Madison

All members of the Madison County Medical Society have paid Association dues for 1949.

Marion

The regular meeting of the Marion County Medical Society was held on April 20 at the "1890 House" in Ocala. Dr. Henry L. Harrell, delegate to the Association's annual meeting, reported on the meetings of the House of Delegates.

Drs. John N. Moore and Eugene G. Peek, Jr., appealed to the members for contributions for the Cancer Society Fund in order that the cancer clinics at the hospital may be continued.

Members present included Drs. Hugh H. Barfield, Richard C. Cumming, T. Hartley Davis, Bertrand F. Drake, Edwin C. Hanson, Henry L. Harrell, Eaton G. Lindner, Carl S. Lytle, William J. McGovern, John N. Moore, Robbins Nettles, Eugene G. Peek, Jr., Ralph E. Russell, Robert E. Thompson, and Harry F. Watt. Drs. John P. Moore and Charles H. Blandford were guests.

Suwannee

All members of the Suwannee County Medical Society have paid 1949 Association dues.

OBITUARIES

Orville H. Cribbins

Dr. Orville H. Cribbins of Sarasota died on Jan. 25, 1949 at the Sarasota Hospital. He was 68 years of age.

Dr. Cribbins was born on Nov. 17, 1880 in Trimble County, Ky. He was graduated from the University of Nashville Medical Department in 1906, and the following year was married to Miss Mabel Fowler. He practiced medicine in Tennessee until 1918 when he entered the United States Army Medical Corps. Upon his discharge as a captain in 1919, he opened offices in Sarasota.

He was one of the founders of the Sarasota Hospital and was a member of the staff from the day the hospital was opened in 1924. He was a member of the Sarasota County Medical Society, which he served as president in 1937, and a member of the Florida Medical Association and the American Medical Association.

Dr. Cribbins was an active member of the First Baptist Church in Sarasota, having served as a deacon since 1919. He also was affiliated with the Sarasota Bay American Legion Post.

Survivors include his wife, Mrs. Mabel Fowler Cribbins; a brother, Louis Cribbins, and a sister, Mrs. Annie Kendall, both of Carrollton, Ky.

Hobart Endicott Warren

Dr. Hobart E. Warren of Palm Beach died suddenly at a local hospital on March 17, 1949 after suffering a cerebral hemorrhage. He was 80 years of age.

Dr. Warren was born on Sept. 26, 1868, the son of Rufus and Alice Marean Warren of Cambridge, Mass. He was graduated from Harvard University in 1891 and from the Harvard Medical School in 1894. After two years as surgical house officer at the Massachusetts General Hospital in Boston, Dr. Warren studied medicine in Vienna for a year. On his return, he was an instructor in anatomy at Harvard for two years, and for the four following years held a similar position at Denver University and Gross Medical College in Denver, at the same time serving as surgeon at three hospitals in that city. Returning to Massachusetts, he practiced in Beverly Farms and was on the Beverly Hospital staff from 1913 to 1925.

In 1917 Dr. Warren, with his wife, the former Miss Mary McHugh of Boston, began spending the winter seasons in Palm Beach and engaging in private practice. They later made their permanent home in Palm Beach. He was a member of the staff of the Good Samaritan Hospital from 1918 to 1941 and was an honorary member of the staff of St. Mary's Hospital.

Dr. Warren specialized in internal medicine. He was a member of the Palm Beach County Medical Society, the Florida Medical Association and the American Heart Association, and was a fellow of the American Medical Association. He also was a member of the Everglades Club in Palm Beach, the Harvard Club in Boston and the Dunes Club of Narraganset, R. I.

In addition to his wife, he is survived by a daughter by a previous marriage, Miss Lucia Warren of North Hollywood, Calif.

Harold Augustine Ryan

Dr. Harold A. Ryan of Miami Beach died suddenly of a heart attack on Feb. 25, 1949 in the home of a patient. He was 44 years of age.

Dr. Ryan was graduated from the Columbia University College of Physicians and Surgeons, New York City, in 1929. He had practiced medicine, specializing in cardiovascular diseases, in Miami Beach since 1931.

He was a member of the Dade County Medical Association, the Florida Medical Association and the American Medical Association.

Survivors include his wife, Mrs. Helen Ryan; three sons, Harold, Jr., Brenny and Thomas; a daughter, Margaret; and a brother, Edmund Ryan of Los Angeles, Calif.

Roland Thatcher White

Dr. Roland T. White of Orlando died in the Florida Sanitarium on March 5, 1949 after a long illness. He was 84 years of age.

Dr. White completed his medical education at the Chicago Homeopathic Medical College in 1886. In 1887 he became a member of the American Institute of Homeopathy and in 1903 he took an extended tour of the clinics of Europe.

He opened offices in Orlando in 1920 and practiced medicine in that city until a few years before his death. He was a prominent citrus grower, and was president of the Lakeview Citrus Company and the Orlando Citrus Growers' Association.

Dr. White was a member of the Orange County Medical Society and the Florida Medical Association and was a fellow of the American Medical Association.

Surviving are three nephews, James White of Detroit, David White of Columbus, Ohio, and I. W. Heaton of Orlando.

(Continued from page 788)

ing. LOUISIANA—NEW ORLEANS: Ned W. Holland. MAINE—BREWER: Calvin M. Thomas. MICHIGAN—DETROIT: Chester A. Doty. MINNESOTA — ST. PAUL: R. O. Leavenworth. MISSOURI—KANSAS CITY: Harold V. Zuber. NEW HAMPSHIRE—GLENCLIFF: Paul C. Burnett. NEW JERSEY—LEONIA: J. Bennett Edwards. NEW YORK—CLINTON: Claude S. Johnson. NEW YORK CITY: Clarence G. Bandler, Cushman D. Haagensen, Saul Miller.

OHIO—CINCINNATI: E. S. Simmonds. SIDNEY: E. P. Sparks, Jr. PENNSYLVANIA — PHILADELPHIA: L. H. Clerf. STATE COLLEGE: Grover C. Glenn, Joseph P. Ritenour. SOUTH CAROLINA—DUE WEST: W. L. Pressly. GREENVILLE: John W. Parker, Jr. TEXAS—DALLAS: Tom E. Smith. VIRGINIA—SANDY LEVEL: M. E. Mease. WEST VIRGINIA—PARKERSBURG: William W. Davis, Paul L. McCuskey, R. S. Widmeyer. WISCONSIN—MADISON: Wm. J. Ganser. RACINE: Louis Fazen, Jr.

Other Guests

GAINESVILLE: F. J. Miller, D.D.S. JACKSONVILLE: Mr. Ernest R. Gibson, Mr. John C. Lee, Mr. Nelson P. Moyer, Mr. H. A. Schroder. MIAMI: J. Ernest Edwards, D.D.S.

CANADA — MONTREAL: Mr. Paul Beaudoin. GEORGIA—EMORY UNIVERSITY: Miss Anna Thurman. MICHIGAN—DETROIT: Mr. Rex Humphrey. MISSOURI—KANSAS CITY: Mr. Mac F. Cahal.

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Auxiliary President's Message

You have bestowed on me simultaneously, a high and distinct honor and a grave responsibility. Both I shall assume with dignity and humility, adding the word "duty" to my creed of "Beauty as I see it, hear it and feel it all about me."

The elevated position we occupy as doctors' wives just naturally carries with it grave responsibilities, but in the state of emergency that we are now in, these responsibilities have become intensified. We cannot do less than meet them with a courageous spirit, assume them with a challenge, and shoulder them with a loyalty and determination to do all that is in our power to keep the high standard of the medical profession ever above the reach of the politicians' hands.

There is no question of where we stand or what our job is. We must act quickly. Individually and as an organized group, your job and my job is to bring enlightenment to the public, to our neighbors and to every man and woman on the street, acquainting them with the facts of compulsory health insurance, pointing out the threats, not only to medicine and the medical world, but to our American way of life.

Our course is charted. Our goal is set. We cannot do less for our doctors.

Mrs. Charles F. Henley.

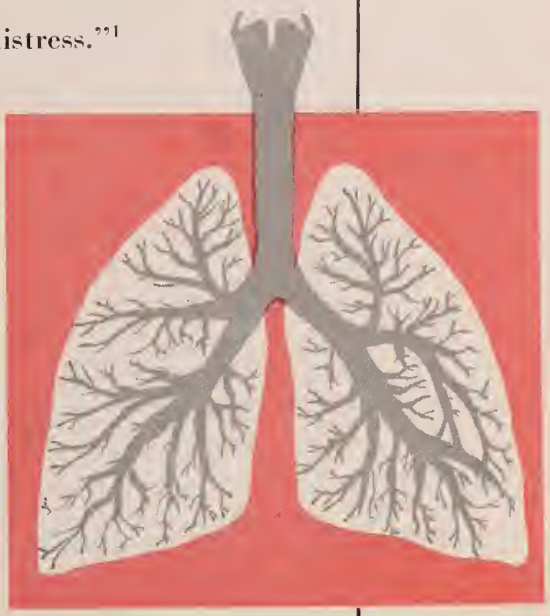
Auxiliary Is Organized in Escambia County

The organizational meeting of the Escambia Chapter of the Woman's Auxiliary to the Florida

(Continued on page 801)

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Medical Association was held on March 15 at the Pensacola Yacht Club.

The meeting was called to order by Mrs. Arthur J. Butt, Jr., acting as temporary chairman. Dr. Walter C. Payne, then president-elect of the Florida Medical Association, was introduced and explained the purpose of the Association's Committee of Forty, a newly-organized committee which will cooperate in the A. M. A. National Education Campaign.

Mrs. Robert J. Jahn, first vice president and State organizer of the Woman's Auxiliary, spoke on the "Objects of a Woman's Auxiliary."

The following officers were elected: Mrs. William P. Hixon, president; Mrs. Mozart A. Lischkoff, vice president; Mrs. Joseph W. Douglas, recording secretary; Mrs. Lee Sharp, corresponding secretary; Mrs. Joe I. Turberville, treasurer; Mrs. Sidney G. Kennedy, Jr., parliamentarian.

The constitution and by-laws were adopted and the newly-organized chapter also adopted a resolution opposing any form of national compulsory health insurance.

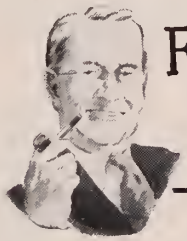
Luncheon was served to 45 charter members.

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From where I sit
by Joe Marsh

Remember How We Talked?

It went like this at the Hooper's last night. Hap's eighteen-year-old daughter is talking about "a real gone guy —solid—out of this world, but def."

"Now what kind of language is that supposed to be?" Hap barks. "Can't she speak English?"

"I'll translate it for you," Ma Hooper says, "in the language of the twenties, when you *were about twenty years old. She simply means this fellow is the 'cat's whiskers.' Remember how* we *used to talk sometimes?" Hap went back to reading his newspaper.*

From where I sit, it's easy to criticize the other person when we don't take a good long look at ourselves. Sure, there'll always be some differences. I'm fond of a temperate glass of beer and maybe you would prefer ginger ale—but let's just live and let live. Because when we go out of our way to find things to find fault with in others, chances are they can find a few in us.

Joe Marsh

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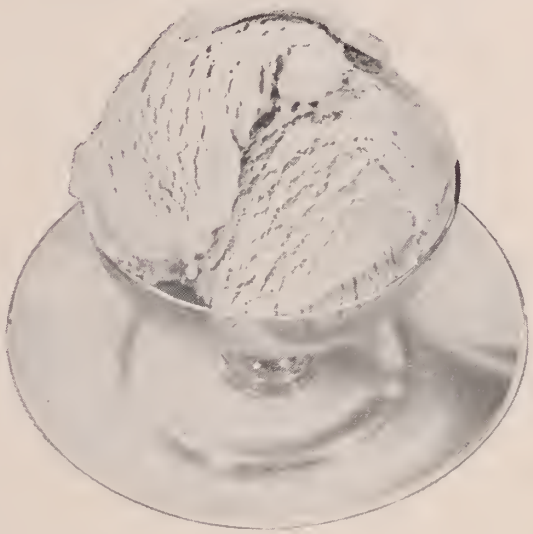
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Esophageal Surgery, One Week, starting October 10.
Thoracic Surgery, One Week, starting June 20.
Breast & Thyroid Surgery, One Week, starting June 27.
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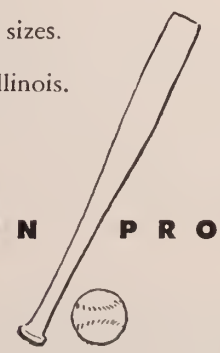
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SCHEDULE OF MEETINGS

ORGANIZATION	PRESIDENT	SECRETARY	ANNUAL MEETING
Florida Medical Association	Walter C. Payne, Pensacola	Robert B. McIver, Jacksonville	Hollywood, Apr. 23-26, 1950
Florida Medical Districts	Russell B. Carson, Ft. Lauderdale	Council Chairman	
A-Northwest	William P. Hixon, Pensacola	Taylor W. Griffin, Quincy	Quincy, 1949
B-Northeast	Charles C. Grace, St. Augustine	Cleland D. Cochrane, Daytona Beach	Palatka, 1949
C-Southwest	H. Quillian Jones, Ft. Myers	M. Crego Smith, Clearwater	Sebring, 1949
D-Southeast	Erasmus B. Hardee, Vero Beach	S. Marion Salley, Miami	Ft. Lauderdale, 1949
Florida Specialty Societies			
Derm. and Syph., Soc. of	A. Buist Litterer, Miami	Wesley W. Wilson, Tampa	Hollywood, Apr. 23, 1950
Genl. Practice of Med.	M. Crego Smith, Clearwater	Walter E. Murphree, Gainesville	" "
Health Officers' Society	Roger F. Sondag, Jacksonville	Lorenzo L. Parks, Jacksonville	" "
Industrial & Railway Surgeons	F. Hardy Bowen, Jacksonville	J. H. Mitchell, Jacksonville	" "
Neurology & Psychiatry	James G. Lyerly, Jacksonville	William H. McCullagh, Jacksonville	" "
Ob. and Gynec. Society	Chas. J. Collins, Orlando	Dorothy D. Brame, Orlando	" "
Ophthal. & Otol., Soc. of	Bascom H. Palmer, Miami	W. Jerome Knauer, Jacksonville	" "
Orthopedic Society	Charles B. Mabry, Jacksonville	Eugene L. Jewett, Orlando	" "
Pathological Society	James N. Patterson, Tampa	Gretchen V. Squires, Pensacola	" "
Pediatric Association, State	Edgar W. Stephens, W. P. Beach	Hugh A. Carithers, Jacksonville	" "
Proctologic Society	Dean W. Hart, St. Petersburg	Frederick E. Farrer, Miami	" "
Radiological Society	James F. Pitman, Lake City	Floyd K. Hurt, Jacksonville	" "
Urological Society	Milton M. Coplan, Miami	Russell B. Carson, Ft. Lauderdale	" "
Florida—			
Basic Science Exam. Board	Paul A. Vestal, Winter Park	M. W. Emmel, D.V.M., Gainesville	Gainesville, June 11, '49
Dental Society, State	T. C. Henslee, D.D.S., Miami	Larry Schulstad, D.D.S., Bradenton	
Hospital Association	Mr. H. Louie Wilson, Gainesville	Mr. H. A. Schroder, Jacksonville	November, 1949
Hospital Service Corporation	Mr W E Arnold, Jacksonville	Mr. H. A. Schroder, Jacksonville	Jacksonville, Feb. 14, '50
Medical Examining Board	Homer L. Pearson, Jr., Miami	Frank D. Gray, Orlando	Jacksonville, June 26-28, 1949
Medical Postgraduate Course	Turner Z. Cason, Jacksonville	Chairman	Jacksonville, June 20-25, '49
Medical Service Corporation	Leigh F. Robinson, Ft. Lauderdale	Herbert E. White, St. Augustine	
Nurses Association, State	Mrs. Elsie M. Airheart, Tampa	Miss Helen Shearston, Miami	Sarasota, October, '49
Pharmaceutical Association, State	Mr. D. M. Weaver, Miami	Mr. R. Q. Richards, Ft. Myers	
Public Health Association	Turner E. Cato, Miami	Mr. Fred B. Ragland, Jacksonville	West Palm Beach, Oct. 6-8, '49
Tuberculosis & Health Assn.	Mr. Dewey Knight, Miami	Mrs. Basil E. Kenney, Sr., Port St. Joe	Panama City, April, 1950
Woman's Auxiliary	Mrs. Charles F. Henley, Jacksonville	Mrs. C. R. Morgan, Jr., Miami	Hollywood, Apr. 24-26, '50
American Medical Association	R. L. Sensenich, South Bend, Ind.	Geo. F. Lull, Chicago	Atlantic City, June 6-10, 1949
Southern Medical Association	Oscar B. Hunter, Washington, D. C.	C. P. Loranz, Birmingham	Cincinnati, Nov. 14-17, '49
Alabama Medical Association	Frank C. Wilson, Birmingham	Douglas L. Cannon, Montgomery	Birmingham, Apr. 20-22, '50
Georgia, Medical Assn. of	Edgar Hill Greene, Atlanta	Edgar D. Shanks, Atlanta	
S. E. Hospital Conference	Mrs. Jewell Thrasher, Dothan, Ala.	Mr. L. H. Gunter, Montgomery	April 5-7, 1950
Southeastern Allergy Assn.	Oscar Swineford, Charlottesville, Va.	Kath. B. MacInnis, Columbia, S. C	Columbia, S. C., 1950
Southeastern, Am. Urological Assn.	James J. Ravenel, Charleston, S. C.	Russell B. Carson, Ft. Lauderdale	Edgewater Park, Miss., Feb. 1-5, '50
Southeastern Surgical Congress	Gilbert Douglas, Birmingham, Ala.	B. T. Beasley, Atlanta	

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	Escambia *Santa Rosa*	Alvyn W. White, M.D. 24 W. Chase St. Pensacola	Arthur J. Butt, Jr., M.D. 1101 N. Palafox St. Pensacola	2nd Tuesday 8:00 P.M.	61	54	A-1-50 William P. Hixon, M.D. Pensacola
	Franklin-Gulf	Albert L. Ward, M.D. Port St. Joe	Donald H. Anderson, M.D. Port St. Joe	3rd Tuesday Odd Months	7	6	
	Jackson *Calhoun*	Daniel A. McKinnon, M.D. Marianna	Francis M. Watson, M.D. 120 Deering St. Marianna	3rd Thursday 7:30 P.M.	19	17	
	Walton-Okaloosa	Arthur G. Williams, Sr. Lakewood	Ralph B. Spires, M.D. DeFuniak Springs	3rd Thursday 8:00 P.M.	14	100%	
	Washington-Holmes	N. J. Dawkins, M.D. Vernon	B. W. Dalton, M.D. Chipley		5	100%	
B	Columbia *Baker-Hamilton*	Robert B. Harkness, M.D. 525 E. Duval St. Lake City	Thomas H. Bates, M.D. 27 W. Madison St. Lake City	1st Monday 7:30 P.M.	16	100%	
	Leon-Gadsden-Liberty-Wakulla-Jefferson	Merritt R. Clements, M.D. 1232 N. Monroe Street Tallahassee	Edward C. Love, Jr., M.D. Masonic Temple Bldg. Quincy	Quarterly 7:30 P.M.	44	42	A-2-51 Taylor W. Griffin, M.D. Quincy
	Suwannee	Joshua M. Price, M.D. Live Oak	Irby H. Black, M.D. 918 W. Howard St. Live Oak		5	100%	
	Madison	A. Franklin Harrison, M.D. Madison	Merwin E. Buchwald, M.D. Madison		5	100%	195
	Taylor *Dixie-Lafayette*	Walter J. Baker, M.D. Foley	Ralph J. Greene, M.D. Perry	Last Friday 8:00 P.M.	4	3	
	Alachua *Bradford, Gilchrist Union*	Alva L. Cobb, Jr., M.D. 505 W. University Ave. Gainesville	F. Emory Bell, M.D. Box 400 Gainesville	2nd Tuesday 8:00 P.M.	39	36	
	Duval *Clay*	Raymond R. Killinger, M.D. 225 W. Ashley St. Jacksonville	Janet G. Leser, M.D. 1016 LaSalle St. Jacksonville	1st Tuesday 8:15 P.M.	246	207	
	Marion *Levy*	Robert E. Thompson, M.D. Holder Bldg. Ocala	Bertrand F. Drake, M.D. Professional Bldg. Ocala	3rd Wednesday 12:30 P.M.	28	26	B-3-50 Charles C. Grace, M.D. St. Augustine
	Nassau	David G. Humphreys, M.D. Fernandina	John W. McClane, M.D. Fernandina	Last Friday 8:00 P.M.	9	100%	
	Putnam	Grover C. Collins, M.D. 502 Reid St. Palatka	Lawrence G. Hebel, M.D. 119 N. 4th St. Palatka	2nd Tuesday 6:00 P.M.	9	100%	
	St. Johns	Reddin Britt, M.D. Box 565 St. Augustine	S. Raymond Cafaro, M.D. Exchange Bank Bldg. St. Augustine	3rd Tuesday 8:30 P.M.	15	14	
C	Brevard	Charles E. Russell, M.D. 16 Magnolia St. Cocoa	Theodore J. Kaminski, M.D. Box 576 Melbourne	2nd Tuesday	14	100%	
	Lake *Sumter*	Leroy H. Octjen, M.D. Leesburg	William L. Musser, M.D. Mount Dora	1st Wednesday 7:30 P.M.	21	2	B-4-51 Cleland D. Cochrane, M.D. Daytona Beach
	Orange *Osceola*	Robert P. Henderson, M.D. 544 N. Orange Ave. Orlando	Gerald W. Jones, M.D. American Bldg. Orlando	3rd Wednesday 8:00 P.M.	138	123	
	Seminole	Leonard I. Munson, M.D. Touchton Bldg. Sanford	Frank L. Quillman, M.D. Box 158 Sanford	2nd Tuesday 5:30 P.M.	12	100%	
	Volusia *Flagler*	Joseph H. Rutter, M.D. Rt. 1, Box 303-A Daytona Beach	Robert L. Miller, M.D. 258½ S. Beach St. Daytona Beach	2nd Tuesday 7:30 P.M.	53	46	584
D	Hillsborough	William M. Rowlett, M.D. Box 786 Tampa	Herschel G. Cole, M.D. 315 Wallace S. Bldg. Tampa	1st Tuesday 8:00 P.M.	152	149	
	Manatee	Willis W. Harris, M.D. First National Bank Bldg. Bradenton	Joseph A. Gibson, M.D. Palmetto	3rd Tuesday 7:00 P.M.	22	17	C-5-51 M. Crego Smith, M.D. Clearwater
	Pasco-Hernando-Citrus	Donald G. Bradshaw, M.D. Zephyrhills	W. Wardlaw Jones, M.D. Box 247 Dade City	2nd Thursday 7:00 P.M.	12	11	
	Pinellas	Francis H. Langley 190 18th Ave. St. Petersburg	Whitman C. McConnell, M.D. 313 First Federal Bldg. St. Petersburg	1st Monday 6:30 P.M.	164	163	
	Sarasota	Millard B. White, M.D. 151 S. Pineapple Ave. Sarasota	Talmadge S. Thompson, M.D. Box 224 Venice	2nd Tuesday 8:30 P.M.	26	23	
	DeSoto-Hardee-Highlands-Charlotte-Glades	John A. Simmons, M.D. Box 430 Arcadia	Charles H. Kirkpatrick, M.D. Box 389 Arcadia	2nd Tuesday 8:00 P.M.	29	28	
	Lee *Collier, Hendry*	Curtis R. House, M.D. 2 Darling Bldg. Ft. Myers	Joseph L. Selden, Jr., M.D. 416 Richards Bldg. Ft. Myers	3rd Monday 7:30 P.M.	23	22	C-6-50 H. Quillian Jones, M.D. Ft. Myers
	Polk	Byron Y. Pennington, M.D. Lake Wales	John W. Vaughn, M.D. Box 475 Lakeland	2nd Wednesday 7:00 P.M.	78	69	506
D	Indian River	John P. Gifford, M.D. Vero Beach	William L. Fitts, 3rd, M.D. Vero Beach Arcade Vero Beach	2nd Tuesday 8:00 P.M.	8	100%	
	Palm Beach	William E. Bippus, M.D. Comeau Bldg. West Palm Beach	Cecil M. Peek, M.D. 535 S. Flagler Dr. West Palm Beach	3rd Monday 8:00 P.M.	90	86	D-7-50 Erasmus B. Hardee, M.D. Vero Beach
	St. Lucie-Okeechobee-Martin	Adrian M. Sample, M.D. Box 897 Ft. Pierce	Jerome A. Megna, M.D. 706 S. 6th St. Ft. Pierce	3rd Thursday 8:00 P.M.	13	11	
	Broward	Paul G. Shell, M.D. 420 Sweet Bldg. Ft. Lauderdale	Scottie J. Wilson, M.D. 309 Blount Bldg. Ft. Lauderdale	4th Tuesday 8:00 P.M.	65	61	
	Dade	John D. Milton, M.D. 1105 Huntington Bldg. Miami	Benjamin G. Oren, M.D. 628 duPont Bldg. Miami	1st Tuesday 8:30 P.M.	503	387	D-8-51 S. Marion Salley, M.D. Miami
	Monroe	Frank E. Bowser, M.D. 420 Simonton St. Key West	Wallace H. Mitchell, M.D. 217 Duval St. Key West	2nd Thursday 8:00 P.M.	14	100%	693

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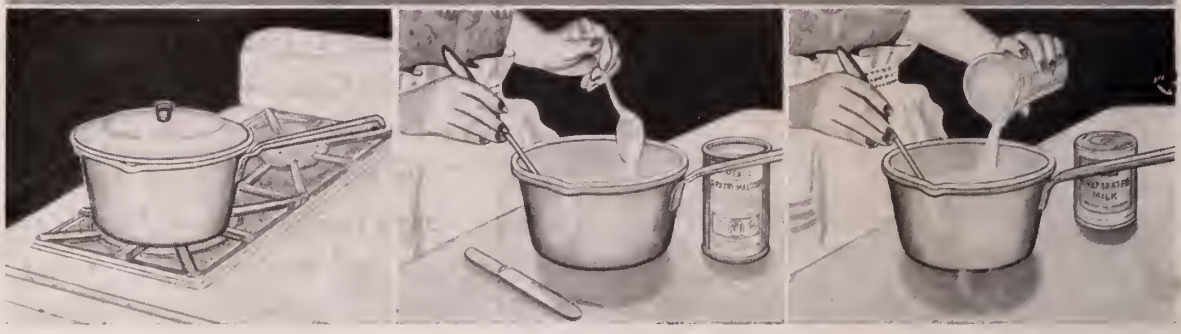
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1 Boil water.

2 Stir in Dextri-Maltose while water is hot.

3 Add evaporated milk and stir.



OR

WITH WHOLE MILK

1 Mix whole milk and water.

2 Heat until almost boiling and stir in Dextri-Maltose.

3 Boil gently for three minutes.



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